Wyoming Health Council Incident Report Form

Definition: ***Incident*** – any event which might possibly result in harm or a problem for a patient, volunteer, employee or a visitor.

Instructions: Please complete this form *immediately* following the incident. Incident reports must be completed for medication errors, employee or volunteer accidents (e.g., a fall, needle stick), and for *any* incident or event which might possibly result in a negative outcome. (If in doubt – fill it out!) Form(s) should be completed by the employee who (1) observed the incident, (2) had the incident, or (3) was first one on the scene. Please email (secured) report (with identifying information removed) to WHC as soon as reasonable. Keep original (with identifying information) at clinic site **Please also call WHC Executive Director or Clinical Director if the incident is of an urgent or serious nature**. *All Pages Must Be Completed and Signed*

Clinic site and phone number____

1. **Identifying Information** *(for the person the incident is concerning): (De-identify report prior to sending to WHC)*

MR # or Initials___________________________________ DOB ___ /____ /________

Gender at birth: Male Female Nonbinary Other Unknown Not disclosed

Identified Gender: Male Female Nonbinary Other Unknown Not disclosed

Preferred Pronouns: He/him/his She/her/hers They/them/theirs Ze/zir/zirs
Something else (specify) ____________

Address ____ City __________

Phone Number ________________________

2. Relationship to Clinic: Patient Employee Volunteer Visitor Other (specify) _____________

3. Date of Incident ______________ Time of Incident ________ a.m. or p.m.

4. **Type of Incident:** Medication error Fall/Injury HIPAA breach Product defect/recall Blood exposure
Violence Adverse medical outcome Other (specify)_________________________

5. If incident is injury to an employee, was a Workers' Compensation claim filed? Yes No
If **yes**, provide case #
If **no**, explain why not.

6. Report(s) made to: Agency Director: In person Email (secured) Phone
Medical Director: In person Email (secured) Phone
WHC: Email (secured) Phone

7. Report made to other parties (e.g., employee's private physician, police, etc.): Yes No
If **yes**, to whom and when? ____

8. **Description of Incident:** (Describe exactly what happened, who was involved, what the circumstances were, and what you observed, including pertinent information prior to the incident and any witnesses, and what you and others have done in response. (Use additional sheets as needed.)

9. *Signatures*:

____

Person Completing Report (signature)	(printed name)	Date

____

Agency Director *or* Medical Director (signature)	(printed name)	Date

Received by:

____

WHC Executive Director (signature) *or* WHC Clinical Director	(printed name)	Date