OCCURRENCE REPORT (Confidential Report to Legal Counsel)

DATE OF THIS REPORT	DATE/TIME OF OCCURRENCE	PERSON FILLING OUT REPORT – NAME/TITLE
NAME OF PARTY INVOLVED	IDENTIFICATION OF PARTY (pt. Caregiver, staff)	AGE OF PARTY INVOLVED: ____ under 14 ____ 25 – 39 ____ 65 & over ____ 14 – 24 ____ 40 - 64

ADDRESS OF OCCURRENCE (if applicable)	LOCATION OF OCCURRENCE (i.e. bedroom, yard – if applicable)
WITNESSES – IF ANY (Include full name, address and phone number)	CHECK HERE OF THIS WAS AN UNWITNESSED OCCURRENCE ☐

NATURE OF OCCURRENCE:
____ Fall ____ Sharps incident ____ Abuse ____ Neglect ____ Burn ____Equipment Failure ____ Communicable Disease
____ Medication Error (State medication involved _____) ____Theft ____Body Fluid Exposure
____ Other: _____

NARRATIVE DESCRIPTION OF OCCURRENCE – BE SPECIFIC (use back side If necessary):
ANNALYSIS OF WHY THIS EVENT OCCURRED – List specific reasons (use back side if necessary):

MENTAL STATUS BEFORE / AFTER OCCURRENCE (if applicable):	VITAL SIGNS (if applicable):
____/____ Alert ____/____Disoriented ____/____ Sedated ____/____Unconscious ____/____ Senile ____/____ Other	BP _____ Temp _____ Pulse _____ Resp. _____

DISPOSITION – INCLUDE SPECIFIC NAMES AND LOCATIONS AS APPLICABLE:

SEEN BY:	TREATMENT:	WHO WAS NOTIFIED:
_____ Physician: _____	_____ X-Ray: _____	_____ Primary MD: _____
_____ ER: _____	_____ Follow up by MD:_____	_____ On-Call MD: _____
_____ Other: _____	_____ Sent To (specify): _____	_____ Agency Supervisor:_____
		_____ Family/caregiver: _____

HOW CAN THIS OCCURRENCE BE PREVENTED IN THE FUTURE (Include corrective actions implemented):

SIGNATURE OF PERSON COMPLETING THIS FORM: _____ DATE: _____

SIGNATURE OF SUPERVISOR: _____ DATE: _____

SIGNATURE OF QA MANAGER: _____ DATE: _____

DATE PRESENTED TO QA COMMITTEE: _____

CONFIDENTIAL – DO NOT PHOTOCOPY

THIS REPORT IS NOT PART OF THE MEDICAL RECORD