Accident/Incident Report

smart start pediatrics

DATE OF INCIDENT: _____ **TIME:** _____ **AM / PM**

WHO WAS INVOLVED IN THE INCIDENT? (LIST ALL THAT APPLY)

NAME	**CONTACT NUMBER**	CHECK ONE
		☐ PATIENT ☐ EMPLOYEE ☐ VISITOR
		☐ PATIENT ☐ EMPLOYEE ☐ VISITOR
		☐ PATIENT ☐ EMPLOYEE ☐ VISITOR

TYPE OF INCIDENT/INJURY: ☐ **FALL** ☐ **MEDICATION** ☐ **OTHER:** _____

DETAILS:

_____ _____

SIGNATURE OF EMPLOYEE/INCIDENT WITNESS **DATE**

THE FOLLOWING IS TO BE COMPLETED BY A HEALTHCARE PROVIDER

DID ACCIDENT/INCIDENT RESULT **IN AN INJURY OR POTENTIAL INJURY?** ☐ **YES** ☐ **NO**

NAME OF INJURED (POTENTIALLY INJURED) PARTY: _____

ADDRESS: _____

PHONE NUMBER(S): _____

DESCRIPTION OF INJURY OR POTENTIAL INJURY & ANY TREATMENT PROVIDED OR RECOMMENDED:

FOLLOW UP RECOMMENDED: _____

_____ _____

HEALTHCARE PROVIDER SIGNATURE **DATE**

SUBMIT THIS FORM TO THE OFFICE MANAGER WITHIN 24 HOURS OF INCIDENT

_____ _____

MANAGEMENT SIGNATURE **DATE**

ATTACH ADDITIONAL PAGES IF NECESSARY FOR DOCUMENTATION

Clear Form