Instructions for Completing the Incident Report Form

Incidents are defined as those actions or situations that may lead to further consequences at a later time. It is essential to document these situations that involve either clients or employees. The Incident Report is used for this documentation. The form is available through the Department Secretaries and the Program Supervisors or Administrators.

All information on the form must be typed or printed. An employee involved in an incident will complete the form. When an incident involves a client the first medical responder will be responsible for the completion of the form. NOTE: Items that are shaded must be completed.

Client/Employee

- Check the appropriate client/employee box in the shaded area above the Involved Party section.

Involved Party

- Complete all information in this block. NOTE: DOB is date of birth.
- If the involved party is a minor, complete the Parent/Guardian Information block.
- If the involved party is an employee, complete the Employee Information block.

Incident Information

- Complete date and time of incident.
- Check appropriate facility box.
- If the incident did not occur at an agency location, check 'other' box and complete next section giving an exact location.
- If the incident did occur at an agency location, complete the next section giving a room number or describe the exact location.

Narrative of Incident

- Describe the details of the incident specifying who, what, when, where and how it occurred. If additional space is needed, mark the 'Continued on Back Page' box and complete the narrative on the back page.
- List any witnesses of the incident.
- Describe the body part(s) involved, if any (i.e., left thumb, right knee, etc).
- Check the appropriate Personal Protective Equipment (PPE) in use box.

Response to Incident

- List name(s) of agency personnel responding to the incident.
- Describe how the responders assessed the situation and any response to it. If additional space is needed, mark the 'Continued on Back Page' box and complete the response on the back page.

Outcome

- Describe the response of the involved party to the intervention described above. If additional space is needed, mark the 'Continued on Back Page' box and complete the outcome on the back page.

Follow-up required

- Mark appropriate box for follow-up.
- List any Fact Sheets given.
- If any additional forms were initiated (Emergency Response, Drug Reaction) mark the appropriate box(es).
- Mark the appropriate box to which the involved party was released.

Signature

- The person completing the Incident Report must print their name and sign and date this section.
- On the reverse side, if the involved party was a client, they or their parent/guardian must sign the claimant box. The person completing the report signs in the box next to the claimant.

Forwarding of form

- The Incident Report needs to be passed up the chain of command to the appropriate manager within 24 hours of the incident.
- If a person in the chain of command is unavailable, the Incident Report is passed up the chain of command to the next available manager. The chain of command is outlined in OP 1000.002.
- The director/assistant director/deputy director passes the Report to the Risk Manager who forwards it to the Legal Department, the Incident Review Committee and other appropriate follow-up response.

OKLAHOMA CITY-COUNTY HEALTH DEPARTMENT
INCIDENT REPORT

FOR OFFICE USE ONLY
TRACKING # _____

Client
Employee

PRINT OR TYPE REPORT

OSHA Recordable

INVOLVED PARTY:						**INCIDENT INFORMATION:**							
Name:						Date:		Time:		A.M.	P.M.		
Address:						Facility:	Main		West		TB		
							Other:						
Phone:						Room/ Exact Location:							
SSN/ID:													
DOB:		Male		Female									

PARENT/GUARDIAN INFORMATION (if minor)				**EMPLOYEE INFORMATION**							
Name:				Date of Hire:							
Address:				Job title:							
				Date Employer Notified of Accident:							
Phone		Relationship		Did you miss any work?	**Yes**		**No**		Last day worked:		

Narrative of Incident: (Please specify who, what, when, where and how)

Witness(es):

Body part(s) involved:

Personal Protective Equipment used **Yes** **No** **N/A** Continued Page 2:

Response to Incident: Name(s):

Continued Page 2:

Outcome:

Continued Page 2:

Follow Up Required	Yes	No	Fact Sheet(s) Given:				
		Emergency Response Form Attached			Drug Reaction Form Attached		
Released to:	Hospital	EMSA	Home	Work		Private Physician	

Acknowledgements of person completing form: I hereby certify the foregoing to be correct to the best of my knowledge.	Printed Name	Signature	Date

Manager/Supervisor	Date	Program Administrator	Date
Section Chief	Date	Deputy Director	Date

Incident Report must be completed and submitted to Supervisor within 24 hours of incident. Submit both pages.

Incident Report Page 2 Continuation:

FOR OFFICE USE ONLY TRACKING #_____

PRINT OR TYPE REPORT

Involved Party's Name		**Incident Date**	
ID (SSN, DOB, etc.)			
Narrative of Incident: (cont.)			
Response to Incident: (cont.)			
Outcome: (cont.)			

Printed Name	Signature	Printed Name	Signature
Claimant		Person completing report	
Date		Date	

Submit both pages.