**Incident Report Form** **Home Health Care Solutions, LLC**

Date of Incident:_____ Time: _____ Department: _____

Patient Involved: _____

MR # : _____ Patient's Phone No. _____

**Check all that apply**:

- □ Incident has caused injury or harm to a patient or Agency visitor
- □ Incident interfered with the delivery of care to the patient
- □ Incident was caused by equipment failure in the home
- □ Incident caused equipment in the home to fail
- □ Incident was due to an improper application of company policies, procedures or professional standards of practice

**Description of Equipment Involved:**

_____

_____

**Describe Incident. Include time of incident and identify any witnesses to the incident.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Did the Incident occur in the presence of an Agency staff member? □ yes □ no
Is patient oriented? □ yes □ no
Does patient use an assistive device for ambulation? □ yes □ no
Does the patient have a caregiver in the home? □ yes □ no
If yes, was the caregiver home when the Incident occurred? □ yes □ no

Signature of employee submitting report: _____

**Notification of Occurrence**:

□ Patient's Physician : _____ Date:_____

□ Immediate Supervisor : _____ Date:_____

□ Other : _____ Date:_____

**Physician's Instructions:**_____
_____
_____
_____
_____
_____
_____

**Supervisory Followup:** _____
_____
_____
_____
_____

**Supervisory Signature**:_____ Date:_____

| **REVIEWED BY:** | **REVIEW DATE:** |
|---|---|
| □ **Administrator** | _____ |
| □ **Medical Director** | _____ |
| □ **Other:**_____ | _____ |