Corporate Office:
500 N Central, Suite 740
Glendale, CA 91203
U.S.A.

Phone: 818.547.0497
Fax: 310.861.5558
E-Mail: mlodge@vqrginc.com
Web Site: www.vqrginc.com

Review Center:
4th Floor, 1st Life Building
174 Salcedo St., Legaspi Village
Makati City, Philippines

Phone: + 632.816.4590
Phone: + 632.816.4550
Fax: + 632.816.4554

VISIONQWEST HEALTHCARE SERIVES

INCEDENT REPORT FORM

MEDICAL/SNF FACILITY: ____
ADDRESS: ____
CITY / STATE / ZIP: __________________________ / _______ / ___________

CHARGE NURSE NAME: ____
PHONE NUMBER: ____

YOUR NAME: ____
PHONE NUMBER: ____

PATIENT NAME: ____ AGE: _______________

Male / Female (circle one)

INCIDENT INFORMATION

Type of Incident (circle one): Admin Emergency Injury Illness Other

Type of injury or illness ____

(examples: sprain, burn, bruise/contusion, fever, vomiting, dislocation, rash, blister, laceration, respiratory, hypothermia, hand injury, etc)

LOCATION OF INJURY ON PATIENT: ____

DATE OF INCIDENT: ______________ TIME OF DAY _______________

Narrative: Please write a detailed description of the incident and the factors that led up to it. Include names, times, statements, contributing factors, witnesses, treatment and follow-up. Attach any photos or witness statements. Continue on additional sheets if needed

____

____

____

____

____

____

____

MEDICAL TREATMENT (please check and describe all that apply):

__ Incident Medical Treatment Given ________________________________ by whom: ___________________

__ Emergency Transportation Called 911 / Private Ambulance Transport (circle one)

__ EMS (911 – ambulance) called by whom ____

__ Medication administred type ___________________ Amount _____________ By _____________________

FOLLOW-UP: Please attach additional sheets of paper if needed to document follow-up)

Date condition of Patient / Treatment Given Initials

Analysis: Nurse and Supervisor should discuss the incident and write comments as soon as possible after it happens. A full incident report must be filed with VisionQwest within eight (8) hours of the incident time. Include any recommendations for changes in policy, procedures or training.

____

____

____

____

____

Report Prepared by: ____________________________________ Date: __________________________
Reviewed by Supervisor: ____________________________________ Date: __________________________
Risk Manager Review: ____________________________________ Date: __________________________
Actions taken on recommendations: Date: __________________________

Call the VisionQwest Risk Manager to review the report.

Fax Report to: 310.801.5558 within 8 hours of incident. If it is a high risk incident you must phone call the VisionQwest office. 818.804.5027 Ext 101