THE EYE INSTITUTE FOR MEDICINE & SURGERY

1995 W NASA Boulevard
Melbourne 32904
Phone: 321-722-4443
Fax: 321-722-2334

150 South Woods Drive
Rockledge 32955
Phone: 321-722-4443
Fax: 321-631-1235

5055 Babcock Street N.E.
Palm Bay 32905
Phone: 321-722-4443
Fax: 321-723-3116

INCIDENT REPORT

Privileged and Confidential Information **Not part of the Medical Record**

For Risk Management and Legal Counsel

DO NOT COPY

LOCATION

SURGERY CENTER ☐ **MELBOURNE** ☐ **ROCKLEDGE** ☐

An incident is any happening which is not consistent with the routine operation of the facility or routine care of a particular patient. It may be an accident or situation which may result in an accident.

INDIVIDUAL INVOLVED:

Last _____ First _____ MI ____

DOB _____ Age _____ Male ____ Female ____ Social Security # _____-_____-_____

Medical Record # _____ Phone Number _____

Address _____

City _____ State _____ Zip _____

Admitting Diagnosis: _____ Scheduled Procedure: _____

ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

DATE OF OCCURRENCE / TIME OF OCCURRENCE / IDENTIFICATION

Month _____ Day ____ Year _____ AM _____ PM_____

Patient ☐ Employee ☐
Visitor ☐ Other ☐

Attending Physician _____ Equipment Involved _____ Exact Location of Incident _____

INCIDENT (CHECK ONLY ONE) ATTACH COPY OF CONSENT FORM AS APPROPRIATE

Procedure related ☐	Equipment related ☐	Administrative Issue ☐	Employee Incident ☐
Medication Error ☐	Informed Consent ☐	Informed Consent ☐	Theft loss ☐
Slip/Fall ☐	Adverse Drug Reaction ☐		Needle/sharp stick ☐
	Theft loss ☐		Other ☐

INCIDENT (What, Why: If injury state part of body. If property or equipment, state damage.)

_____
_____
_____

HEALTH STATUS (Clinical condition/status of individual involved-after incident.)

_____
_____

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VITAL SIGNS AT TIME OF INCIDENT

Blood Pressure: _____ Pulse: _____ Respirations: _____ Time Taken: _____

Temperature: _____ Taken by Last Name, First: _____

ACTION TAKEN (Initial care or treatment.)

Attending Physician Notified: YES ☐ NO ☐ Physician's name: _____

Date:_____ Time:_____ Physician's orders: _____

_____

_____

Patient/ Family Member Disclosure? YES ☐ NO ☐ Date Notified:_____Time Notified: _____

Family Member Last Name, First Name: _____

PREPARER

Prepared by: _____ Title Position: _____ Date: _____ Time: _____

INVOLVEMENT (List all persons involved, including witnesses, patients and visitors.)

Name/Title _____ Involvement Type _____

License / SS# _____

Name/Title _____ Involvement Type _____

License/ SS# _____

Name/Title _____ Involvement Type _____

License/ SS# _____

RECOMMENDATIONS

_____

_____

_____

_____

FOLLOW UP

_____

_____

_____

_____

RISK MANAGER REVIEW

Internal Risk Manager Designee: _____Date:_____Time:_____

Licensed Healthcare Risk Manager/ Consultant: _____ Date :_____

Date Received By Benedict And Associates, Inc. Initials_____