

Non-Employee Occurrence Report

1. Treatment issue Slip/fall Communication Medication Medical Equipment Other

2. EXACT LOCATION OF OCCURRENCE:

Date of Occurrence: _____ Time of Occurrence: _____

3. PERSON PREPARING REPORT:

Name: _____ Department: _____ Phone: _____
Date report prepared: _____ Time report prepared: _____

4. PERSON INVOLVED:

Name (last, first, m.i.) _____

Address: _____ Phone: _____

Medical Record Number (if applicable) _____ DOB: _____

Please **circle one** of the following, **and** indicate **which** clinic, school, destination or department:

Patient - Clinic: _____

Student-School: _____

Visitor – Destination: _____

Volunteer – Department: _____

5. WITNESSES: Yes No

Who: _____ Contact #: _____

Is witness an employee? Yes No Department: _____

6. PROBLEM or ISSUE: Please describe exactly WHAT, WHY, HOW, (R) or (L) side of body, which finger etc.

7. FALLS:

Activity/circumstances of patient when fall occurred: _____

Treatment given or action taken: _____

8. Seen by Physician: Yes No

Physician assessment: _____

Physician's Signature: _____ Date: _____

9. Disposition of patient/outcome: _____

Do not Place in Medical Record