PRESTIGE HOME CARE AGENCY
Incident Report Form

Name	**Date of Incident**
DOB	**Time of Incident**
Phone	**Location of Incident**
Witnessed by	**Reported by**

Type of Incident (check all that apply)	
☐ Patient Event	☐ Staff Event
☐ Observed Fall	☐ Fall
☐ Unobserved Fall	☐ Needlestick
☐ Found patient on floor	☐ Assault
☐ Serious bruise(s)	☐ Animal Bite
☐ Abuse/Neglect	☐ Cut or Bruise
☐ Sentinel Event	☐ Auto Accident
☐ Injuries of unknown source	☐ Injury due to Equipment
☐ Patient Injury (specify)________________ ________________	☐ Staff Injury (specify) ________________ ________________
☐ Other event that causes serious harm and requires immediate attention to patient	☐ Other event that causes serious harm and requires immediate attention to staff person

Description of Incident

Did this result in patient injury? ☐ Yes ☐ No
If yes, describe injury ____
____
____
____

Agency notified: ☐ Yes ☐ No Date and time notified: ____________________

Relative/Guardian notified: ☐ Yes ☐ No Date and time notified: ____________________

Called 911: ☐ Yes ☐ No Date and time notified: ____________________

Follow-up Action Taken

Date/Print Name and Title of Person Completing Report____________________________

Signature of Person Completing Report____________________________

Date/Signature office staff____________________________