20730 Holyoke Ave. #125
P.O. Box 565
Lakeville, MN 55044

Phone: 952-985-0672
Fax: 952-985-0675
www.integrahc.com

INCIDENT REPORT

TO BE COMPLETED BY REPORTING EMPLOYEE

Client Name: ______________________________ Employee Name: ______________________________

Employee Position: ______________________________ Supervisor: ______________________________

Date/Time of Incident: ____

Place of Incident: ____

Family informed of incident? Yes ☐ No ☐ N/A ☐

If yes, who was informed? ____

Describe incident:

Actions taken:

Outcomes:

Reported by: ______________________________ Date reported: ______________ Time: ____________

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TO BE COMPLETED BY OFFICE STAFF

Date/Time Incident was Reported to Office Staff: ____________________

Family informed of incident? Yes ☐ No ☐ N/A ☐ If yes, who was informed? ____________________

Client QP Name: ____________________ QP informed of incident? Yes ☐ No ☐ N/A ☐

Client Diagnosis (If applicable): ____________________

Physician informed? Yes ☐ No ☐ Physician Name: ____________________ PH: __________

By whom? ____________________ Physician instructions given? Yes ☐ No ☐

If yes, comment:

Describe incident:

Actions taken:

Outcomes:

Follow-up Needed:

Reporting Supervisor: ____________________________________ Date reported: ______________ Time: ______________