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**Medical Incident Report Form**

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| --- |
| **INCIDENT DETAILS** |
| Date and time of the incident | **:** |  |
| Location of the incident | **:** |  |
|  |  |  |
| Describe the incident | **:** |  |
|  |  |  |
|  |  |  |
| Details of the witnesses, if any | **:** |  |
|  |  |  |

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| **NATURE OF THE INCIDENT** |
| Select the appropriate category for the medical incident: |
|  |  |
| [ ]  | Medication Error |
| [ ]  | Fall or Injury |
| [ ]  | Adverse Reaction |
| [ ]  | Surgical Complication |
| [ ]  | Equipment Failure |
| [ ]  | Other (specify**) :** |  |

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| **PATIENT INFORMATION** |
| Name of the patient | **:** |  |
| Age | **:** |  |
| Gender | **:** |  |
|  |  |  |
| Medical History (if known) | **:** |  |
|  |  |  |

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| **INCIDENT DESCRIPTION** |
| Provide a detailed description of the incident, including any relevant information about the patient's condition, treatment, and any contributing factors | **:** |  |
|  |  |

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| **IMMEDIATE ACTIONS TAKEN** |
| Describe the immediate actions taken to address the incident, provide necessary medical intervention, and notify appropriate medical personnel | **:** |  |
|  |  |

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| **REPORTING TO AUTHORITIES** |
|  |  |  |
| Specify whether the incident has been reported to relevant medical authorities or regulatory bodies | **:** | [x]  YES [ ]  NO  |
|  |  |  |
| If yes, provide details of the report and any case/reference numbers | **:** |  |
|  |  |  |

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| **FOLLOW-UP ACTIONS** |
| Outline any follow-up actions, investigations, or reviews that will be conducted as a result of the incident | **:** |  |
|  |  |  |

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| **PREVENTIVE MEASURES** |
| What preventive measures can be implemented to avoid similar incidents in the future? | **:** |  |
|  |  |  |

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| **ADDITIONAL COMMENTS** |
| Is there any additional information or comments you would like to include? | **:** |  |
|  |  |  |

|  |
| --- |
| **REPORT FILTER** |
| Name | **:** |  |
| Job Title / Role | **:** |  |
| Contact Details | **:** |  |

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