MEHARRY
MEDICAL COLLEGE

REPORTABLE EVENT FORM

This report and the information contained therein is a privileged communication to the Office of Corporate Compliance and is protected under the Attorney/Client privilege. The Office of Corporate Compliance has authorized the Risk Management Specialist to collect and investigate incidents reported therein. (If you have any questions, call 327-6444).

Please complete this report (in its entirety) in the event of an accident, discovery of a hazardous condition, or any occurrence which is not consistent with routine operation of the institution or routine care of a patient. Submit all forms to Risk Management, 5th Floor, LRC, in the Office of Corporate Compliance.

1 NAME _____
ADDRESS _____
_____
PHONE (H) _____ (W) _____
AGE _____ SEX _____

2 EXACT LOCATION OF INCIDENT	BLDG/DEPT	FLOOR	ROOM NO.	DATE	TIME AM/PM
DISCOVERED BY		TITLE			

3 INCIDENT
__ 1E Slip/Fall
__ 2E Medication
__ 3E Injury
__ 4E Equipment
__ 5E Procedures
__ 6E Elopement/AMA
__ 7E Sharp Instr. Injury
__ 8E Theft/Break-In
__ 9E Auto Accident
__ Fire/Flood
__ Evacuation
__ Other

CONCISE DESCRIPTION OF OCCURRENCE (STATE SIGNIFICANT FACTS IN CHRONOLOGICAL ORDER, I.E., INCLUDE SPECIFIC ENTRANCE/EXIT OR CONDITION SURROUNDING INCIDENT)

For sharp injuries, list type and manufacturer:

4 WITNESSES

NAME	HOME ADDRESS	TELEPHONE NO.
NAME	HOME ADDRESS	TELEPHONE NO.

5 BACKGROUND
☐ Inpatient
☐ Outpatient

PATIENT'S DIAGNOSIS | ADMISSION DATE

SURGICAL PROCEDURE/OUTPATIENT TREATMENT

Medication Within Past 8 Hours ☐ Yes ☐ No | NAME OF MEDICATION | ☐ SEDATIVE ☐ LAXATIVE ☐ DURETIC ☐ OTHER

6 ☐ Visitor ☐ Employee ☐ Student ☐ Other

REASON FOR BEING AT FACILITY

Department	Title	On Duty ☐ YES ☐ NO

7 Treatment

Was There an Injury? ☐Yes ☐No
Patient/Family Aware of Incident? ☐Yes ☐No
Was Examination or Treatment Refused? ☐Yes ☐No

_____ Injured Person's Signature, If Yes
Attending Physician Notified? ☐Yes ☐ No – If Yes, Date _____ Time _____ ☐AM ☐PM
X-Ray Ordered ☐ Yes ☐ No Results (If Known) _____
Diagnosis and Recommendation _____

_____

_____ SIGNATURE _____ MD

8a REPORTING
EMPLOYEE MUST REPORT INCIDENT TO SUPERVISOR. STUDENT MUST REPORT INCIDENT TO THE DEAN OF STUDENT AFFAIRS. VISITOR MUST CALL THE DEPARTMENT OF PUBLIC SAFETY AT 327-6666.

8b FOLLOW-UP
INVESTIGATION REPORT WILL BE COMPLETED BY RISK MANAGEMENT.

9a
TYPE OR PRINT NAME OF PERSON COMPLETING THIS REPORT

9b

SIGNATURE OF PERSON COMPLETING THIS REPORT	TITLE	DATE

This report is for data analysis and loss control purposes only. It is not to be construed as notification to the insurance company of possible claim.