South Cove Community Health Center
Incident/Complaint Report Form

PRIVILEGED AND CONFIDENTIAL DOCUMENT

(NOT A PART OF THE MEDICAL RECORD)

Date of Event: _____ Date Reported: _____

Time: _____ a.m. _____ p.m.

Involves: ☐ Patient ☐ Staff ☐ Visitor/Vendor

Location of Occurrence:

☐ Exam Room ☐ Restroom ☐ Hall ☐ Grounds

☐ Waiting Room ☐ Other: _____

Name: _____

MR #: _____

DOB: _____

Day of Week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Other Occurrences

- ❑ Patient/family complaint
- ❑ HIPAA violation
- ❑ Medical emergency
- ❑ Patient-to-patient aggression
- ❑ Theft (item: _____)
- ❑ Other: _____

Treatment/Diagnostic/Procedure Error

- ❑ Delay/error of contract service (lab, radiology, etc.)
- ❑ Omission (treatment, test, other: _____)
- ❑ Patient refused treatment
- ❑ Incomplete treatment
- ❑ Wrong patient
- ❑ Wrong treatment/procedure/diagnosis
- ❑ Surgical complication
- ❑ Other: _____

Falls

- ❑ Fall from exam table
- ❑ Fall from chair/commode
- ❑ Fall while walking assisted
- ❑ Fall while walking unassisted
- ❑ Other _____
- ❑ Witnessed ❑ Unwitnessed
- ❑ Provider notified

Infrastructure/Property-Related Occurrence

- ❑ Equipment failure (item: _____)
- ❑ Fire on premises
- ❑ False (fire) alarm
- ❑ Flood on premises
- ❑ Power failure more than 4 hours
- ❑ Vandalism
- ❑ Other: _____

Medication Error Type

- ❑ Allergic or adverse reaction
- ❑ Wrong dose
- ❑ Wrong patient
- ❑ Wrong drug
- ❑ Wrong route
- ❑ Wrong time
- ❑ Given without an order
- ❑ Other: _____

Medication Error Reason

Transcription/entry related

- ❑ Illegible provider order
- ❑ Incomplete provider order
- ❑ Entered on wrong patient record/chart
- ❑ Other: _____

Dispensing/distribution related

- ❑ Order not sent to/received by pharmacy
- ❑ Order electronically sent to wrong pharmacy
- ❑ Wrong drug dispensed
- ❑ Medication mislabeled
- ❑ Other: _____

Administration related

- ❑ Medical record not verified prior to administration
- ❑ Dose given, but not documented
- ❑ Other: _____

Staff-Related Occurrence

- ❑ Patient-to-staff aggression
- ❑ Accidental injury by mechanical device/equipment (item: _____)
- ❑ Accidental injury due to exposure to hazardous/toxic substances (type: _____)
- ❑ Injury due to lifting/moving patients, furniture, or equipment
- ❑ Exposure to blood or bodily fluid*
  - ❑ Eye splash
  - ❑ Needle stick
  - ❑ Other: _____

Type of Injury (All Events)

- ❑ Abrasion, laceration
- ❑ Altered mental status
- ❑ Burn
- ❑ Contusion (bruise)
- ❑ Electric shock
- ❑ Fracture
- ❑ Infection/contagious disease
- ❑ Musculoskeletal sprain
- ❑ Visual impairment
- ❑ Other: _____

Instructions: This Form is to be filled out by SCCHC Staff and forwarded to the Chief Operating Officer

Brief factual description of occurrence or complaint:

Actions taken by staff:

Notifications made:

	YES	NO
Risk manager	☐	☐
Police department	☐	☐
Guardian/parent/family member	☐	☐
External agency: _____	☐	☐
Department of Health	☐	☐
Other _____	☐	☐
Occurrence documented in chart	☐	☐

Witnesses and/or Visitors:

Name: _____

Address/phone #/e-mail:_____

Name: _____

Address/phone #/e-mail:_____

Name of Reporter: _____

Signature of Reporter: _____ Date: _____

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