Alliance
Physical Therapy Partners

607 Dewey Ave. Suite 300 Grand Rapids, MI 49504

Occurrence Report

ATTORNEY-CLIENT PRIVILEGE

Confidential review document. This document is part of the records of a professional peer review committee, whose functions include professional review, reduction of morbidity and mortality, and the improvement of care. It is prepared for, and is made absolutely confidential pursuant to 42 USC 11111, MCL 331,531-533, 333.20175, 333.21515 and all other relevant state and federal laws. Redisclosure of this information by any administrative agency is strictly prohibited.

Instructions: Complete form to report any event which is not consistent with the routine department operation or expected clinical outcome of patient care. Report immediately (within 24 hours) to supervisor; if death or injury to Risk Manager

IDENTIFICATION DATA

1. ☐ Patient ☐ Visitor ☐ Customer ☐ _____	2. Type: ☐ Hospital IP ☐ Hospital OP ☐ Free Standing OP Clinic/practice ☐ Occ Rehab Clinic ☐ SNF/SNU ☐ SNF : Non resident ☐ HHC ☐ IRF/IRU ☐ Work-Fit: Fitness ☐ Work-Fit: Treatment ☐ Work-Fit: Prevention	3. Report Date:
4. Individual's Name: MR# ☐ NA Age: ☐ M ☐ F	5. Facility name and address *(no abbreviations, complete address)*	6. Occurrence Date: Hour: ☐ AM ☐ PM

7. Location: ☐ Therapy dept. ☐ Patient room ☐ Work-Fit Center ☐ Job Site ☐_____	☐ PT ☐ OT ☐ SP ☐ ____	8. Witnesses: ☐ yes, insert name(s) contact # ☐ No _____ _____

OCCURRENCE

9. Type of occurrence: *(check all that apply)* ☐ Patient complaint ☐ During treatment ☐ Related to equipment use ☐ Equipment malfunction Description & Serial # _____ _____ ☐ Fall: ☐ Observed ☐ Eased to floor ☐ Alleged (Pt states) ☐ Patient attended ☐ Using gait belt ☐ Using adaptive device ☐ Area well lit ☐ Personal article damaged or lost ☐ Patient contributed to occurrence ☐ Prior mental status: ☐ Confused ☐ Alert ☐ _____	10. Description of Event: (Facts only: Who, What, When, Where, How)	☐ **Additional information attached**

11. Injury: ☐ None apparent ☐ Burn / Chemical Burn ☐ Abrasion / Laceration ☐ Fracture or Dislocation ☐ _____ _____	12. Physician notified: θ no θ yes name: _____ Date_____/_____/_____ Time:	13. Referred for treatment: ☐ no ☐ yes ☐ offered, but declined/refused 14. Treatment by: ☐ ER ☐ MD ☐ Other_____ 15. Reported to client site: ☐ no ☐ yes: date ___/_____/_____

16. Comments from involved party:

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18. Person Reporting signature, title & date:

MANAGER / SUPERVISOR REPORT

INVESTIGATION / FOLLOW UP / COMMENTS:

_____

_____

_____

_____

_____

_____

ANALYSIS / CAUSE

Check all that apply	Description
☐ Equipment Failure/malfunction ☐ Process design (insufficient) ☐ Failure to follow policy & procedure ☐ Policy & procedure followed: policy improvement/revision required ☐ Staff competency / judgment ☐ Patient/Visitor/Customer unanticipated action ☐ Unavoidable / Unable to prevent	

CORRECTIVE ACTION

	Description: (specify completion/target date(s) & responsible parties)
☐ Patient education ☐ Staff education ☐ Staff competency validation ☐ Protocol/policy review & revision ☐ Process review & revision ☐ Equipment repair/replacement ☐ Referral to (*specify in description*) ☐ _____ ☐ NA	

Supervisor Signature Date

Faxed to Alliance Risk Manager on _____ θ Request opinion/response, call _____
616-356-5001 (*Use cover sheet and keep fax confirmation*)

CORPORATE REVIEW *(corporate office only)*

Alliance Health Corporate Review Completed by Date

Further investigation/action: ☐ NA

☐ Carrier/date contacted on_____ ☐ Request opinion/response , call _____

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