

GUARDIAN ANGEL HEALTH AGENCY, LLC

INCIDENT REPORT

Patient MR# _____

Date of Incident _____

TYPE OF INCIDENT

☐ Med. error ☐ Missed procedure ☐ Equipment failure
☐ Patient fall (no injury) ☐ Employee injury ☐ Loss or damage property
☐ Patient fall (with injury) ☐ Patient injury ☐ Inappropriate behavior
☐ Threat of OR Attempted Suicide ☐ Suspicion of Abuse

Other _____

Location _____

Individuals involved: (Please use Patient & Employee's I.D. Numbers)

Name(s) of Witness(es): _____

Description of Incident:

Action Taken:

Physicians notified by: _____ Date _____ Time _____

Name of Physician _____

Interventions to prevent recurrence:

Signature of individual filing report: _____ Date _____

Signature of DOCS/RN: _____ Date _____

GUARDIAN ANGEL HEALTH AGENCY, LLC
POLICIES AND PROCEDURES - ORIENTATION