NON-EMPLOYEE OCCURRENCE REPORT

GENERAL INFORMATION

DATE OF OCCURRENCE	TIME OF OCCURRENCE ☐ AM ☐ PM	DATE OF ADMISSION	SEX ☐ M ☐ F	AGE

☐ IN-PATIENT ☐ OUTPATIENT ☐ VISITOR ☐ OTHER (SPECIFY)

UNIT	LOCATION (BLDG., FLOOR, RM.)	DEPARTMENT/SERVICE

DIAGNOSIS	SURGERY (DATE)

OCCURRENCE TYPE (CHECK ONE) FOR FALL* or MEDICATION** complete related section below.

☐ FALL* ☐ MEDICATION** ☐ BLOOD PRODUCTS ☐ INFILTRATION ☐ TREATMENT ☐ DIETARY ☐ BURN ☐ ELOPEMENT ☐ COUNT DISCREPANCY (O.R. ONLY) ☐ EQUIPMENT – SERIAL NO. _____ ☐ OTHER (SPECIFY) _____

DESCRIPTION OF OCCURRENCE

WITNESSES (NAME, TITLE, DEPT./ADDRESS)	PHYSICIAN NOTIFIED (NAME)	TIME ☐ AM ☐ PM

PHYSICIAN'S ASSESSMENT AND TREATMENT

SIGNATURE	PRINT NAME	I.D. CODE	WAS TREATMENT REQUIRED? ☐ YES ☐ NO	WERE DIAGNOSTIC TESTS REQUIRED? ☐ YES ☐ NO

*FALLS – RELATED FACTORS (CHECK ALL THAT APPLY) ☐ OBSERVED ☐ UNOBSERVED

☐ GOT OOB UNASSISTED ☐ TRANSFER BED/CHAIR ☐ UNASSISTED AMBUL. ☐ RELATED TO TOILETING ☐ PATIENT ON STRETCHER
☐ CLIMBED OVER SIDE RAIL ☐ OOB IN CHAIR ☐ ASSISTED AMBUL. ☐ RELATED TO COMMODE ☐ PATIENT DID NOT FOLLOW INSTRUCTIONS
☐ WET FLOOR ☐ OTHER (SPECIFY) _____

MED. ADMIN. WITHIN 24 HRS.:
☐ SEDATIVE/HYPNOTIC ☐ ANTIHYPERTENSIVE
☐ ANALGESIC/ANESTHESIA ☐ VASOACTIVE
☐ PSYCHOACTIVE AGENT ☐ NONE OF THE ABOVE

GENERAL ASSESSMENT: (PRIOR TO FALL)
☐ CALL BELL IN REACH ☐ VISUAL DEFICIT
☐ ALL SIDE RAILS UP ☐ MOTOR DEFICIT
☐ ALTERED MENTAL STATUS ☐ RESTRAINTS IN USE
☐ HEARING DEFICIT ☐ AT RISK TO FALL

ACTIVITY ORDER: (PRIOR TO FALL)
☐ OOB AD LIB ☐ OOB/BRP
☐ OOB W/ ASST. ☐ BEDREST
☐ OOB TO CHAIR

**MEDICATION – (CHECK ALL THAT APPLY) TOTAL NUMBER OF OCCURRENCES_____

OCCURRENCE TYPE:
☐ OMISSION ☐ WRONG DOSE ☐ EXTRA DOSE ☐ WRONG TIME ☐ WRONG MEDICATION ☐ WRONG ROUTE ☐ WRONG PATIENT ☐ OTHER (SPECIFY)_____

ROUTE:
☐ P.O. ☐ I.V. ☐ I.M. ☐ S.Q. ☐ TOPICAL ☐ P.R. ☐ S.L. ☐ OTHER (SPECIFY)_____

CLASSIFICATION:
☐ ANALGESIC ☐ ANTICONVULSANT ☐ CARDIAC ☐ HYPOGLYCEMIC ☐ NARCOTIC/SEDATIVE ☐ STEROID
☐ ANTIBIOTIC ☐ ANTIHYPERTENSIVE ☐ DIURETIC/CATHARTIC ☐ I.V. FLUID ☐ PSYCHOACTIVE AGENT ☐ PARENTERAL NUTRITION
☐ ANTICOAGULANT ☐ BRONCHODILATOR ☐ OTHER (SPECIFY) _____

COMPLETED BY	(SIGNATURE)	PRINT NAME	TITLE	DATE
REVIEWED BY	(SIGNATURE)	PRINT NAME	TITLE	DATE
DEPT. HEAD	(SIGNATURE)	PRINT NAME	TITLE	DATE