

X-RAY ASSOCIATES

PATIENT/VISITOR INCIDENT REPORTING FORM

Section A: General Information (Patient/Visitor Information)

Last Name	First Name
Patient <input type="checkbox"/> Visitor <input type="checkbox"/>	File No:
Home Phone Number:	Other Phone Number:

Section B: Description of the Event

When: Date of Event (MM/DD/YYYY)	Time of Event
Date Reported	Time Reported
Where: Location of office	Room
Incident involved: Injury <input type="checkbox"/> Property <input type="checkbox"/> Incorrect Exam <input type="checkbox"/> Other <input type="checkbox"/>	
Condition of patient prior to incident: Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Language Barrier <input type="checkbox"/> Other <input type="checkbox"/>	
What happened? (Description of the event and how it occurred)	
Was First aid administered? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, by whom?	
Assessment of patient/visitor after incident	
Patient/Visitor checked by: Technologist <input type="checkbox"/> Radiologist <input type="checkbox"/> Physician <input type="checkbox"/>	
Was anyone else injured?	
What factors contributed to the event? How could the event have been avoided?	
Is the patient being recalled for a later date? When?	
Comments:	

Form Completed by:	Telephone Number:
Initial:	Date:

X-RAY ASSOCIATES

PATIENT/VISITOR INCIDENT REPORTING FORM

Section C: General Information

Supervisor's Name

Phone Number

If there was a delay in reporting this event, list reason(s):

Material Damage YES [] NO [] Approximate Value:

Section D: Preventative Measures

Cause of event – Root Causes (e.g., unsafe equipment, lack of training, etc.)

What corrective actions are being taken to prevent recurrence?

Frequency of the task or activity that led to the event:

[] Often (daily or weekly) [] occasional (monthly) [] rare (1-4 times per year)

Has a risk assessment been carried out for the process/activity: YES [] NO []

Have person(s) involved received training or instruction in the work or activity being carried out? YES [] NO []

Was there any supervision of the work or activity being carried out? YES [] NO []

Supervisor's Comments (Additional information on event)

Supervisor's Signature

Date