Incident Report Form

This form can be emailed to: tyler@capabletherapy.com or faxed to 888.275.8136.

Patient's Name:_____D.O.B:_____

Date of Incident:_____/_____/_____ Time:_____AM/PM

Specific Location of Incident _____

Participants:
Patient's Name:_____

Clinician:_____
Other :_____

_____

Other Witness(es) if any:

Name of Witness:_____ Contact Phone Number:_____

Description of Incident: (How did accident happen, where were participants at the time of the incident, what were participants doing, specify any equipment or tools used).

_____
_____
_____
_____
_____

Immediate Action Taken (how did you respond?)

_____
_____
_____

[ ] Patient instructed to see Physician or go to emergency room

Name of Person Completing this report: _____

Signature:_____Title:_____Date:_____

Follow-up (as needed): (To be completed by Administration):_____

_____

Note: All incidents with injury must be communicated immediately to the administrator.