INSTRUCTIONS FOR COMPLETION
PATIENT INCIDENT REPORT FORM

HEALTH

INCIDENT REPORTING:

The **Patient Incident Report Form** is for incidents involving Texas A&M Health (TAMH) patient incidents, within the circle of care, occurring within clinics, hospitals, nursing home, or any other clinical venue.

Report should be completed by the employee involved in the event. It must include factual details only on the event, including date, time, and place; a simple description of what happened; and what is known of the outcome. **DO NOT include opinions, conclusions, or assignment of blame.**

Report must be submitted within 2 business days of the event. **If the Adverse or Sentinel Event resulted in a death, the event should be submitted within 1 business day.**

All Incidents and Near Misses, within the circle of care, must be reported on the Patient Incident Report Form.

1. **Near Miss (or Close Call):** Patient safety event that did not reach the patient. An event which has potential to result in an illness, injury, or harm but did not reach the patient or other individuals. Near Miss events include, but are not limited to:
    a. Documentation; or
        i. incorrect documentation;
        ii. lack of timely documentation; or
        iii. documentation in the wrong chart.
    b. Error in a medication or immunization order.

2. **Incident:** Any event or occurrence that could have resulted, or did result, in harm to a patient.
    a. Adverse Event: Any happening that results in harm, physical or psychological, to a patient that is not consistent with the routine care of a particular patient.
    b. Sentinel Event: A sentinel event is an adverse event involving death or serious physical or psychological injury; or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Sentinel Events do not automatically imply negligence or malpractice
    c. Litigious Intent: Significant threat or indication from a patient or their family that they intend to pursue legal actions against our practice or providers.
    d. Investigations by the Texas Medical/Dental Board or other regulatory bodies: Any situation that gives rise to an investigation by the Texas Medical/Dental Board or any other regulatory body shall be reported as an adverse event.

INTERNAL REVIEW:

Please refer to the College of Dentistry or College of Medicine policy on their Internal Review process.

FOLLOW-UP REPORT:

A follow-up report may be required including a summary of the internal review, corrective and/or assessment action plan and whether a peer review was completed.

Save the blank form to your desktop, open and type into the form fields electronically.

Save the completed form to your computer, naming the file with the date of the incident, i.e. "Patient Incident MM.DD.YYYY"

Email the form to patient-incidents@health.tamu.edu and your department head/supervisor.
For College of Dentistry: copy email to Gracie Perez in Clinical Affairs - gperez@tamu.edu

Delete the saved incident report from your computer after is has been successfully submitted by email.

If you have any questions, please contact:

HSC Compliance and Risk Management
Texas A&M University Health Science Center
Clinical Building 1, Suite 3200
8441 Riverside Parkway, Bryan, TX 77807

PATIENT INCIDENT REPORT FORM

HEALTH

Attending Physician / Resident / Dentist / Clinical Staff

Full Name	Email Address	Phone
Title	**Department**	**Date Report Prepared**

Location Date & Time

◯ Inpatient at: _____ ◯ Outpatient / Clinic Patient at: _____ ◯ Other, please explain: _____

Date / Time of incident	Location: Street, City, Building, Room No. (Be specific)
◯ AM ◯ PM	

Patient Information

Admission Date:_____Admission Diagnosis:_____

Patient Last Name	Patient First Name	Middle Initial	Phone
Address	**City, State, Zip Code**	**Date of Birth**	**Gender**
			◯ M ◯ F ◯ Unknown

Incident Description

Describe What Happened *(Please state facts only. Use additional sheet if necessary)*:

Nature of Harm Ill Health Damage

Immediate Action Taken

Transported for Care?	◯ Yes ◯ No	Seeking Private Care?	◯ Yes ◯ No

Provide details of actions taken:

WITNESSES

Name	Email Address	Phone No.
1.		
2.		
3.		

REPORTED BY

Name	Email Address	Phone No.
Title	**Department**	**Date**

FOR INTERNAL USE ONLY

Department Head Supervisor **Review / Action**	**Review** **Action** **Recommended** ◯ **Required** ◯ **Signature** **Date**
TAMH Administration **Review / Action**	**Review** **Action** **Recommended** ◯ **Required** ◯ **Signature** **Date**
TAMH Compliance **Review / Action**	**Review** **Action** **Recommended** ◯ **Required** ◯ **Signature** **Date**
Notes / Comments	**FOR RISK MANAGEMENT USE ONLY** **Signature** **Date**

HSC Compliance and Risk Management
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