DEPARTMENT OF HUMAN SERVICES
Med-Quest Division, Medical Standards Branch [FAX # (808) 692-8131]

P. O. Box 700190
Kapolei, HI 96707

INCIDENT REPORT

Reportable incident: (Submit within 72 hours of reportable incident.) Check appropriate box below.

[ ] Absence without leave for one or more nights.
[ ] Adverse reaction to a drug, medication error and/or treatment.
[ ] Bodily injury requiring medical intervention.

1.Facility Name			
2. Resident Name	**3. Sex**	**4. Birthdate(mm/dd/yyyy)**	**5. Acuity Level at time of incident [ ]SNF [ ]ICF [ ]ICF/MR [ ]Other**
6. Diagnosis(ses)			
7. Date & Time of incident	**8. Place of incident (e.g., hallway, bedroom, dining area, etc.)**		

(Note: If more space is needed, continue at the back of this form.)
8. Description of incident:

9. Description of the kind & extent of medical intervention: (Include/attach results of diagnostic tests; e.g., xrays, M.D. assessment, etc.)

10. Corrective action(s):

11. Reported to other agency(ies); e.g., APS, DOH, MID: Yes [ ]_____ **No [ ]**
Name(s)

12. Name & Title of reporter: _____

_____ _____
Signature Date

13. If NO reportable incidents have occurred in the facility from Jan.- June or July - Dec., pls. complete below and submit by the 15th of the month following the end of the reporting period.

NO REPORTABLE INCIDENT: [ ] Jan. – June, Year _____ [ ] July – Dec., Year _____

Name & Title of reporter: _____ **Facility Name:** _____

_____ **Date:** _____
Signature

DHS 1147i (2/2000) DO NOT MODIFY FORM