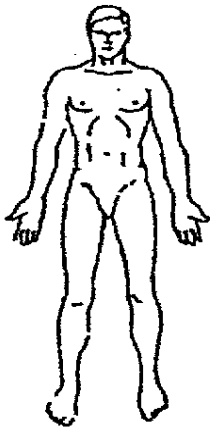


NURSE MANAGEMENT SERVICE OF GEORGIA, INC.
INCIDENT/ACCIDENT REPORT

Person (Last Name) (First Name) (Middle Initial) Involved		Male <input type="checkbox"/> Female <input type="checkbox"/> Age _____ ID# _____		An Incident is any happening which is not Consistent with the routine operation of Client care. It may be an incident or situation Which might result in an accident.
Date of Incident / /	Time of Incident [] AM [] PM	Exact Location of Incident [] Client Room [] Hallway [] Bathroom [] Other		
Client Condition Before Incident [] Normal [] Senile [] Disoriented [] Sedated			Diagnosis:	
<input type="checkbox"/> Employee	Department:	Job Title:		
<input type="checkbox"/> Visitor	Home Address:	Home Phone		
<input type="checkbox"/> Other	Occupation	Reason for Presence at Facility		
Describe exactly what happened, why it happened, and action taken. If an injury, state part of body injured and care/first aid provided. If property or equipment damaged, describe damage:				

Was family/guardian/responsible person notified? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date / /	Time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Family's Name	By whom?
Was Physician notified? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date / /	Time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Physician's Name	By whom?
Was person involved seen by a physician? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date / /	Time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Where	Physician's Name
Was person involved hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date / /	Time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Where	By Whom

Indicate on Diagram Location of Injury
TYPE OF INJURY



1. Laceration
2. Hematoma
3. Abrasion
4. Burn
5. Bruise
6. Swelling
7. Skin Tear
8. None-Apparent
9. Other (specify)



ACCIDENT

1. Fatal
2. Non-Fatal

Name, Address and Phone Number of All Witnesses	
Steps Taken to Prevent Reoccurrence	
Follow-up	
Date of Report	Signature