

Incident Report Form



Subscriber _____

Visitor _____

Employee _____

**This report is to be completed for ALL injuries occurring within a facility.
Report is to be printed and submitted to Risk Management within 24 hours of occurrence.
Fax to: 1-800-873-5292**

Name: _____ Facility Name: _____

Subscriber #: _____ Subscriber D. O. B. _____ O Male O Female

Address: _____
(Street Number. Name. City. State, Zip)

Telephone #: _____ Emergency Telephone #: _____

Incident Date: _____ Incident Time: _____

DESCRIBE INCIDENT (include WHO, WHAT, WHERE, HOW, WHY, ICD-9-CM Code injury elements):

WITNESS (ES) (list persons directly involved):

<u>Name</u>	<u>Position</u>	<u>Address</u>	<u>Phone #</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician Notified? Yes No Time Notified: _____ By Whom? _____

Physician Name: _____ Phone#: _____

Address: _____

Brief Statement of Treatment Given / Recommended by Physician:
