

QUALITY ASSURANCE DOCUMENT - EXEMPT FROM DISCOVERY IAW U.S.C SECTION 1102  
DO NOT RELEASE WITHOUT PERMISSION OF MTF COMMANDER

<b>MEDICAL TREATMENT FACILITY INCIDENT STATEMENT</b>					OMB No. 0701-0135 Expires: 9-30-97			
Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, DIOR, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302; and to OMB, Paperwork Reduction Project (0701-0135), Washington DC 20503. Please DO NOT RETURN your form to either of these addresses. Return your completed form to your Supervisor.								
MEDICAL FACILITY ADDRESS					INCIDENT NUMBER			
1. INCIDENT DATA								
TYPE		DATE	TIME	LOCATION				
2. PERSONAL DATA								
PERSON (Last, First, Middle Initial)			SEX		RANK/GRADE	DOB		
			M	F				
STATUS		SSN	ORGANIZATION					
SPONSOR (Name and Grade)			RELATIONSHIP TO SPONSOR					
ADDRESS (Street, PO Box, City, State, Zip Code)					PHONE NO.			
3. STATUS								
<input type="checkbox"/>	MEDICAL PERSONNEL	DEPARTMENT		JOB TITLE				
<input type="checkbox"/>	VISITOR/OTHER	REASON FOR BEING IN MEDICAL FACILITY						
<input type="checkbox"/>	INPATIENT	REGISTER NO.	UNIT/CLINIC	REASON FOR HOSPITALIZATION				
<input type="checkbox"/>	OUTPATIENT							
4. COMPLETE IF PROPERTY/EQUIPMENT INVOLVED								
DESCRIBE PROPERTY/EQUIPMENT								
5. COMPLETE IF BED INVOLVED								
				YES	NO	UP	DOWN	ORDERED
HEIGHT OF BED ADJUSTABLE				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BED RAILS PRESENT				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOOTSTOOL BY BED				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. COMPLETE IF MEDICATION INVOLVED (Medicine Administered)								
DRUG(s)			<input type="checkbox"/>	ORAL	<input type="checkbox"/>	INJECTION	<input type="checkbox"/>	INTRAVENOUS INFUSION
7. NARRATIVE OF INCIDENT (Give a concise statement of the facts. DO NOT include opinions or conclusions.)								

DO NOT FILE OR REFER TO IN MEDICAL RECORDS

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8. COMPLETE IF PERSON ATTENDED BY HEALTH CARE PRACTITIONER									
WAS PERSON EXAMINED BY PRACTITIONER IN MTF?				DATE		TIME		EXAMINATION LOCATION	
YES		NO							
NAME OF EXAMINING PRACTITIONER			<input type="checkbox"/> NO APPARENT INJURY.			X-RAY ORDERED		<input type="checkbox"/> EXAMINATION AND TREATMENT REFUSED	
						YES NO			
NATURE OF INJURY									
TREATMENT OR DISPOSITION									
9. WITNESS TO INCIDENT									
NAME			GRADE	ADDRESS				PHONE NO.	
TYPED/PRINTED NAME AND TITLE OF PERSON PREPARING STATEMENT					SIGNATURE			DATE	
10. QUALITY SERVICES COMMENTS									
11. NURSING SERVICES REVIEW									
12. CLINICAL DEPT/SVCS, OTHER REVIEW									
13. RISK MANAGER/SAFETY OFFICER REVIEW									
14. QA/RM COMMITTEE REVIEW									
15. SJA REVIEW									