Reset Form Email Print Form

ICE Health Service Corps

Incident Reporting Document

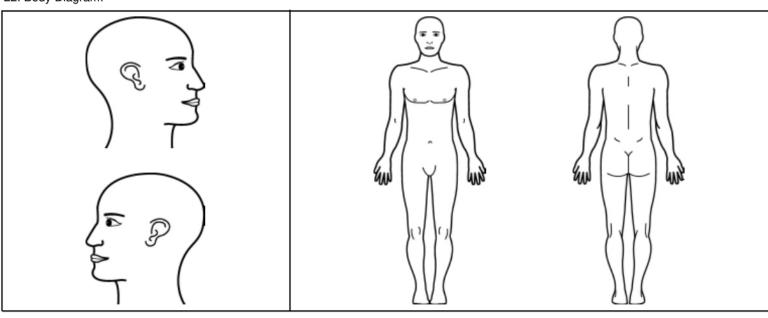
The information placed on this form is confidential and privileged IAW 42 U.S.C. 11137. **UNAUTHORIZED DISCLOSURE CARRIES A FINE UP TO 20,000.** DO NOT FILE OR REFER TO THIS FORM IN PATIENT RECORD. REPORT EVENT TO SUPERVISOR/DEPARTMENT CHIEF IMMEDIATELY. Email completed to: DIHSHQINCIDENTS@dhs.gov This Form must be completed electronically.

1. Date of Event:	2. Time of Event:	Name of Facility:		
4. Age: 5. Gender:		6. (State in block # 16): Detainee Visitor Staff Other		
7. Attending Medical Provider: _		8. Location of Event:		
9. Diagnosis (Medical/Psychiatric in	f any):	10. Work Related: Yes No		
11. Weapons Involved: Yes	☐ No 12. Witnesses: ☐ Yes	No 12a. Name of Witness:		
13. Type of Incident/Ocurrence: Adverse Drug Reaction Airborne Exposure	Equipment Escape	Injury Pharmacy Property Loss or Damage Medication (to include IV) Suicide/Suicide Attempt		
Bloodborne Exposure Fall/Discovered on Floor Medication Administration Other (Explain in narrative block # 16)				
14. Condition After Occurrence (C No Apparent Effect	Check one box only): Minor Injury or Effect	Significant Injury or Effect Death or Loss of Function Other (Explain in narrative blo	ock # 16)	
15. Action Taken				
Yes No Medical Provider No Did Medical Provider X-Rays Ordered/Tak	r See Patient	Yes No tory Tests Ordered/Taken ed to Supervisor/ ment Chief orted to Other Health acility Yes No Infection Control Preca Taken (Explain type of prin narrative block # 16) Other (Explain in narrative block	ecaution	
16. Description of Event (Concise, Factual, Objective Statements), Include Location of Event:				
17. Immediate Intervention (If mo	re space is needed, use a blank sheet of p	paper for continuation):		
Name, Grade, Title of Individu	ial Completing Form (Print)	Signature Date of	Report	
For HQ Use Only: 21. Log Number: 22. Further Analysis Indicated: Yes No				
Last Name:		First Name:		
A#:		Country of Origin:		
Date of Camp Arrival (DCA):		DOB:		
Medical Clinic:		Sex:		
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Incident Reporting Document (Continued)

22. Body Diagram:



23. Evaluation: (Concise Objective Statements e.g., Practice/Procedure variance involving staff. Include other possible contributing factors, etc. and suggested improvement measure if any):

HSA:		Date:
Medical Director:		Date:
Performance Improvement Committee:	Date:	
Last Name:	First Name:	
A#:	Country of Origin:	
Date of Camp Arrival (DCA):	DOB:	
Medical Clinic:	Sex:	