INCIDENT/COMPLAINT REPORT

EMPLOYEE: Return this COMPLETED FORM to your SUPERVISOR as soon as possible.

Name of Person Involved: Eileen Harris

Address: 402 South Center City: Miles City

Phone Number: 503-232-2471 (1 pt) Age: 22 DOB:

SS#: Date of Incident: Today Time: 3:05 p

Exact Location of Incident: Lab

Check Type of Accident:

- ☐ Clerical/Data Entry
- ☐ Communications
- ☐ Testing Process
- ☐ Result Reporting
- ☐ Safety
- ☐ Medical Device Failure
- ☑ Policy/Procedural Violations
- ☐ Adverse Drug Reaction
- ☐ Vehicle Accident
- ☐ Needlestick
- ☐ Exposure to Hazardous Substance
- ☐ Medication Error (Wrong: Route, Dosage, Medication, Schedule

Check:

- ☐ Patient
- ☑ Employee
- ☐ Visitor
- ☐ Volunteer
- ☐ Other

EMPLOYEE: Involved ☑ Yes ☐ No

Were they doing their regular job duties: ☑ Yes ☑ No

Observed by employee: ☑ Yes

Hire Date: 07/07/201 Marital Status: Single

Situation observed only by employee ☐ Yes

Employee Classification: Phlebotomist

Protective Equipment being used: ☐ Yes ☐ No

If not used, why:

Description of Incident/Complaint (Who, What, Where, How, Why, Include sequence of events, personnel involved, body part injured, reason incident occurred) (If medication error include brand name, manufacturer, dosage) (Use additional form if necessary)

Eileen performed lab procedures in the lab without authorization for a family member (father). The family member needed lab tests, but couldn't pay for them. The patient was not a patient of Dr. Raugh. Eileen intended to perform the lab tests and review them herself in order to ensure that her father didn't need additional care. (1 pt/sentence; maximum pts = 3)

Actions Taken by Staff Members:

Eileen was confronted. Eileen was counseled. Incident report initiated. (1 pt/sentence; maximum pts = 3)

Witness Name:	Supervisor	Phone Number:	503-455-6788
Address:	78 Main Street, Miles City, Montana		
MEDICAL FOLLOW-UP: Was medical attention sought:	☐ Yes ☐ No		
Treatment Refused:	☐ Yes ☐ No	First Treatment Date:	
Treatment Physician		Phone Number:	
Address:			
First Day Off Work:		Return to Work Date:	
Duties Restricted:	☐ Yes ☐ No		
Explain:			