Louisiana State University Health Care Services Division
Medical Center of Louisiana at New Orleans

CONFIDENTIAL REPORT OF INCIDENT
NON-CLINICAL OCCURRENCES FORM
FOR EMPLOYEES ONLY

Sample

❑ University Campus ❑ Other MCL Site:_____

If there was an exposure to blood or body fluid, you must stamp the patient's card here.
(Not a part of the medical record)

"An incident is any occurrence that is not consistent with the routine operation of MCL or that does or has the potential to result in a specific harm or loss to a particular individual."

*Forward this to Department Safety Coordinator or Supervisor

REPORT

Who was injured?
Name: _____
Civil Service Job Title: _____
Address: _____
_____
Phone (Home & Work): _____
_____
Hospital #: _____
SS #: _____
Date of Birth _____/_____/_____
Who completed this column?
Name: _____
Title: _____
Phone: _____

When did the incident occur?
(use mm/dd/yr and 24h time)
Date _____/_____/_____
Time_____hr
When was this report completed?
Date _____/_____/_____

Actual location of injury:
❑ University Campus
❑ Other: _____
Department: _____
Cost Center: _____
Building Name: _____
Floor & Room: _____

What type of incident?
❑ Auto Accident
❑ Contact with skin irritant
❑ Inhalation of chemicals / irritants
❑ Foreign body in eye
❑ Bite by: ❑ Animal ❑ Insect ❑ Human
❑ Struck by ❑ moving vehicle ❑ person
❑ other: _____
❑ Strain by lifting, twisting or using tool/ machines
❑ Slip and fall from/on: _____
❑ Striking against object
❑ Stepping on sharp object
❑ Caught in or between machine, mechanical appliance or other: _____
❑ Burn or exposure
❑ Electrical shock
❑ Cut, puncture, scrape
❑ needlestick ❑ scalpel blade
❑ surgical device or appliance
_____
❑ other medical device _____
❑ other non-medical device _____
❑ Other: _____
Was device: ❑ clean ❑ contaminated?
Body part involved: _____

What were you (the injured employee) doing? Be specific. Describe the activity and name tools and devices by brand name and C.E. #:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

INVESTIGATION

Who investigated the incident?
Name: _____
Title:_____Department: _____
Phone: _____
Date investigated _____/_____/_____

Who witnessed the incident?
Name Phone #
_____
_____
_____
_____

How and why did the incident occur?
Describe the full events which resulted in the injury. Include any unsafe conditions and/or contributing factors. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____

Sample

What immediate corrective actions were taken to prevent a reoccurrence of this type of incident? _____
_____
_____
_____
_____

Have similar incidents occurred in the past?
❑ No (if yes, indicate the month/yr)
❑ Yes - to the same individual ____/____
❑ Yes - in the same location ____/____
❑ Yes - doing the same procedure ____/____

What actions are necessary to prevent recurrence (equipment issues, repair, additional training, policy/procedure change, disciplinary action, etc.)? _____
_____
_____
_____
_____
_____

Investigator's Signature: _____

ACTION

Employee Demographics
Sex: ❑ Male ❑ Female
Employment Status:
❑ Part-time ❑ Full-time
Date began to work at MCL: _____/_____/_____
Time employee scheduled to work: _____
Normal starting time: _____h
Is this the normal shift? ❑ Yes ❑ No
If no, reason for being on premises:
_____

Physician's Action
❑ Employee examined
❑ Employee treated
❑ Employee requested to see his/her own MD
❑ Examination unnecessary
❑ Examination necessary, but refused*
❑ Treatment unnecessary
❑ Treatment necessary, but refused*

*Employee required to sign if refusal checked

_____
Employee's Signature

Who examined the patient?
Name: _____
Location: _____
Case/Route Sheet #: _____
Radiological Exam: ❑ Yes ❑ No
Lab Exam: ❑ Yes ❑ No
Patient Disposition: _____
_____
_____
_____
Referred by M.D. to Infection Control/ Employee Health: ❑ Yes ❑ No

If no treatment was rendered at MCL, return this form to your Departmental Safety Coordinator.

Information reported on Safety Coordinator's report:
mo_____ yr_____

Form is to be returned to the Department of Risk Management

If assistance is needed in completing this form, please consult your Departmental Safety Coordinator or the Department of Risk Management at 903-8987.

Employee/Preparer's Signature:
_____
Date: _____
Signature of Department Director or Designee: _____
Date: _____

MCLN 0741 (R 3/07)

Blood/Body fluid exposure must report to Employee Health for follow-up