CPT Therapy Incident Report Form

Facility:
Date:
Time:
Patient Full Name:

Full Name and titles of the employees(s) facility staff or witnesses involved:	
Full name(s) and titles of who was notified (i.e., doctor, supervisor):	
Location of incident:	
Detailed Description of the incident chronologically: Include use of any equipment, gait belt, assist level	
Patient/ Witness statements:	
Objective measures: (Vitals/ AxO / pain level/behavior / etc.)	
Status of patient after incident:	

If therapy treatment was provided after incident, was patient was cleared to continue with therapy by nursing or MD: YES/NO – Include how was session tolerated.	
Additional Comments:	

I attest all of the information entered is accurate. I acknowledge that by typing my name below, I agree that this form of electronic signature is the same as a manual signature.

Signature of Person completing form: _____

Name of Person completing form: _____