Excellence Through Innovation

Fall 2010

OLD DOMINION UNIVERSITY
COLLEGE OF HEALTH SCIENCES
STUDENT INCIDENT REPORT

(Include accidents, exposure to hazardous substance or disease.)

1. **PLEASE PRINT**

Name _____

Address _____

City _____ State _____ Zip Code _____

UIN _____ Phone _____

School _____

2. **OCCURRENCE DATE**_____ Day of Week _____

3. **OCCURRENCE TIME**_____ **AM / PM**

4. **REPORT DATE** _____/_____/_____

5. **LOCATION OF OCCURRENCE** _____

6. **ACTIVITY INVOLVED** (check all that apply)

_____ Lifting Patient
_____ Lifting Other
_____ Invasive Procedure/Injection
_____ Other Patient Care
_____ Non-Work Activity
_____ Transport Patient
_____ Transport Equipment
_____ Equipment Use/Repair
_____ Walking
_____ Hazardous Substance
_____ Infectious Exposure

Explain: _____
_____
_____
_____

Other (explain) _____
_____
_____

7. **TYPE OF INJURY** (check all that apply)

_____ No Apparent Injury
_____ Laceration / Abrasion
_____ Puncture
_____ Burn
_____ Bruise / Crush
_____ Bite / Scratch
_____ Other (explain)

_____ Foreign Body
_____ Strain / Sprain
_____ Fracture
_____ Amputation
_____ Electrical Shock

8. **PART of BODY** (check all that apply)

Left		Right	Left		Right
_____	Head	_____	_____	Elbow	_____
_____	Eye	_____	_____	Hand	_____
_____	Ear	_____	_____	Finger(s)	_____
_____	Face	_____	_____	Wrist	_____
_____	Neck	_____	_____	Leg	_____
_____	Chest	_____	_____	Groin	_____
_____	Abdomen	_____	_____	Knee	_____
_____	Back	_____	_____	Foot	_____
_____	Arm	_____	_____	Toe(s)	_____
_____	Shoulder	_____	_____	Ankle	_____

9. **POSSIBLE CAUSES** (check all that apply)

_____ Unclear as to Policy/Procedure
_____ Patient Initiated Occurrence
_____ Improper Clothing/Equipment
_____ Equipment Defect/Malfunction
_____ Poor Illumination
_____ Other (explain)

_____ Unaware of Safety Hazard
_____ Foreign Material on Floor
_____ Building/Premises Defect
_____ Improper Body Handling

10. **ODU SUPERVISOR NOTIFIED AT TIME OF OCCURRENCE**

_____ Yes _____ No Name _____

11. **DESCRIPTION OF OCCURRENCE**

_____

_____

12. **WITNESSED BY** (please print)

Name_____ Phone _____
Name_____ Phone _____

13. MEASURES TAKEN TO PREVENT REOCCURRENCE

_____

_____

14. **TREATMENT**

_____ No Treatment Necessary
_____ Employee Health
_____ Emergency Room
_____ First-Aid
_____ Refused Treatment
_____ Other

Hospital _____

Explain _____

_____

15. **REFERRED TO PHYSICIAN**

_____ Yes _____ No Treatment Facility _____
Physician's Name _____

Briefly Describe Treatment _____

OR

If incident is a blood or body fluid exposure, please adhere to Blood-Borne Pathogen Post Exposure guidelines. Document only as directed.

16. **DISPOSITION**

_____ Returned to School
_____ Released to Home
_____ Hospitalized – Name of Hospital _____
_____ Fatality
_____ Other (explain) _____

17. **TIME LOSS**

_____ Yes _____ No Estimated Absence _____

18. **SIGNATURES**

Student _____ Date ____/____/____
Clinical Supervisor _____ Date ____/____/____
ODU Course Supervisor_____ Date ____/____/____
Comments _____

_____

_____