



FRONTIER NURSING UNIVERSITY CLINICAL INCIDENT REPORT FORM

1. Use this form to report any unexpected patient incidents related to patient care or treatment, even if there is no adverse patient outcome (this includes errors, safety hazards, injuries and sentinel events).
2. This form is to be completed by FRONTIER NURSING UNIVERSITY students *in addition to* any reporting requirements of the facility/hospital.
3. Notify your RCF & complete this form w/in 48 hours of the incident
- 4.. After completion, please return to Clinical Director at FRONTIER NURSING UNIVERSITY via US mail.

Student Name	Clinical Program
Incident Date	Incident Time

Site Name:
Address:
Dept/Unit:

Identification of Person(s) Potentially Affected by the Incident			
Name		Role	
Name		Role	
Name		Role	

Witnesses, Including Onsite Staff			
Name		Role	
Name		Role	
Name		Role	

Factually describe the incident. (Include only information that is in the chart; no subjective statements). Use additional paper as needed, but be succinct.

Patient Outcome [check appropriate box(es)]

Death	<input type="checkbox"/>	Pain/Prolonged pain	<input type="checkbox"/>	Disruption to services	<input type="checkbox"/>
Critical condition	<input type="checkbox"/>	Patient distress	<input type="checkbox"/>	Unable to assess outcome	<input type="checkbox"/>
Injury	<input type="checkbox"/>	Delay in treatment	<input type="checkbox"/>	Near miss by chance	<input type="checkbox"/>
Ill health	<input type="checkbox"/>	Change to treatment	<input type="checkbox"/>	Near miss by intervention	<input type="checkbox"/>
Temporary deterioration of condition	<input type="checkbox"/>	Prolonged stay in hospital	<input type="checkbox"/>	No adverse effect	<input type="checkbox"/>
Transfer to higher level of care	<input type="checkbox"/>	Radiation overexposure	<input type="checkbox"/>	Other	<input type="checkbox"/>

Student Action Taken as a Result of Incident: (please give brief details - attach separate sheet if necessary)

Student Acknowledgement

Student Name:	Title/Position:
Acknowledgment - I acknowledge that the facts and circumstances reported above are true and accurate to the best of my knowledge:	
Signature:	Date:

MAIL this Incident Report via the United States Postal Service (USPS) to your Clinical Director at the address below within one week of the incident and email your Clinical Director to inform them that this report is being sent.

Note that this incident report is NOT to be sent by email.

Clinical Directors:

FNP specialty: Dr. Katheryn Arterberry, DNP,APRN, FNP-BC: 5601 Trevor Drive, Shreveport, LA 71129

PMH specialty: Dr Susan Piper, DNP, APRN, PMHNP-BC: 11020 State Route 175 S, Greenville, KY 42345

MIDWIFERY/WOMEN'S HEALTH specialty: Dr. Audrey Perry DNP, CNM: 128 Valley View Rd, Myerstown, PA 17067

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Clinical Director Reviewed:	Date:
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