### SECTION A: TO BE COMPLETED BY THE REPORTER OF THE INCIDENT

#### INCIDENT DESCRIPTION

1. NAME OF FACILITY/INSTITUTION
2. DATE OF INCIDENT
3. TIME OF INCIDENT
4. PATIENT’S RN/OTHER INDENTIFICATION NUMBER
5. TYPE OF INCIDENT
6. LOCATION/WARD/CLINIC
7. TYPE OF PATIENT
8. DEPARTMENT(S) INVOLVED

#### IMPORTANT NOTES

- **Date of Reporting:** \__/__/____
- **Language Barrier:** YES/NO
- **Other Type of Incident:**

**Examples of incidents that need to be reported:**

- i. Wrong surgery/procedure – wrong site, side or patient
- ii. Unintended retained foreign body in patient after an operation/procedure
- iii. Error in transfusion of blood/blood products
- iv. Medication error (please fill in MERS form as well)
- v. Patient fall in the facility
- vi. Obstetric related incidents
- vii. Adverse outcome of clinical procedure
- viii. Pre-hospital care and ambulance service related incident
- ix. Radiotherapy related incident
- x. Patient suicide / attempted suicide
- xi. Patient discharged to wrong family members / next-of-kin
- xii. Assault / battery of patient
- xiii. Unanticipated Fire – fire, flame, or unanticipated smoke, heat, or flashes occurring in the facility
- xiv. Others type of incident: __________________________

**BRIEF DESCRIPTION OF WHAT HAPPENED**

The description should explain what happened prior and during the incident and how it occurred. Do include any additional information which you think may lead to the incident.
### PATIENT OUTCOME (please tick one) & IMMEDIATE ACTION – ONLY FOR ACTUAL INCIDENT

8. **OUTCOME OF INCIDENT**

- None
- Mild
- Moderate
- Severe
- Death
- Currently cannot be determined

### IMMEDIATE ACTION FOLLOWING INCIDENT

9. **REPORTED BY**

10. **DESIGNATION:** (please tick one)

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>House Officer</td>
<td>Pharmacist</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>Others:</td>
</tr>
</tbody>
</table>

**SIGNATURE OF REPORTER:**

- Name:
- Date:

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Note: As part of good leadership and clinical governance, please inform the incident to your Head of Department(s) immediately.

### SECTION B: TO BE COMPLETED BY THE RISK MANAGER/ QUALITY MANAGER OF HOSPITAL

1. **ACTION TAKEN:**

   - Mandatory Root Cause Analysis:
     1) Incident with Severe or Death outcome
     2) Other incident/near miss based on the Risk Manager/ Quality Manager assessment
     3) Directive from State Health Department / Ministry.

   (Please tick)

   - "Prescription Slip"
   - Monitor the trend first
   - RCA
   - MIRCA (Multi-incident Root Cause Analysis)

   Additional comments:

2. **e-IR SUBMITTED?**

   Please submit to e-IR within 5 days from the date of the incident.

   Date of Submission: ______ - ______ - ______

3. **RISK MANAGER/ QUALITY MANAGER OF HOSPITAL**

   (please fill in the blanks)

   - Name:
   - Signature:
   - Designation:
   - Date: