

Patient #: (1)		Name: (2)		Unit/ward: (3)		Seq #: (4)	
Incident Date(YYYY/MM/DD): (5)		Incident category code(s): (6)		Shift: 1 2 (7) 3		Dow (Sun = 1): (8)	
Incident Location Code: (9)		Incident Category Code(s): (10) / /		Effect Code(s): (11) / /		Body Part Code(s): (12) / /	
Fall from A: (14)		Patient was B: (15)		Side rails C: (16)		Medication G: (20)	
Med Error Category A: (21)		Error Type B: (22)		Reason for Med Error C: (23)		Med Type D: (24) / /	
SIB Method A: (26)		SIB Patient was B: (27)		SIB Instrument C: (28)		SIB Reason D: (29) / /	
Assault Patient A: (30)		Assault Result B: (31)		Assault Provocation C: (32)		Assault Reason D: (33)	
Death Type A: (34)		Coroner Notified B: (35)		Coroner Status C: (36)		Autopsy Status D: (37)	
Abuse Type A: (38)				Abuse Investigation B: (39)			
AWOL-A: (40)		AWOL-B: (41)		AWOL-C: (42)		AWOL-D: / (43) /	
Date a Time Patient Returned from AWOL: (44)				Was Patient on increased level of supervision at time of incident ? : Yes (45) No			
Was restraint used as part of this incident ? Yes (46) No				Was seclusion used as part of this incident ? : Yes (47) No			

Description of Event(Who, What, Where, When—Reference others involved by Patient Number Only)

(48)

the numbers on this sheet correspond to the numbers on the documentation completion instructions for the SI-815 form

see attachment A

			Signature & Title	Date
Names of Witnesses (49)	Relationship/Title (49)	Location (49)		

Medical Nursing Interventions (Completed by RN –include specific, measurable description of injury and interventions)

(50)

Physician Notified?: Yes (51) No		Date: (52)		Time(Military): (53)		By Whom: (54)	
Physician Name: (55)		Examined: (56) Yes No		Date: (57)		Time(Military): (58)	
				Hospitalized: (59) Yes No		Where: (60)	

Physician findings and recommendations (completed only when the patient is examined by a physician)

(61)

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_