



DATE OF REPORTING: ___/___/___

*Borang boleh diisi dalam Bahasa Malaysia

SECTION A: TO BE COMPLETED BY THE REPORTER OF THE INCIDENT																																																	
INCIDENT DESCRIPTION (Please fill in the blanks)																																																	
1.	NAME OF FACILITY/ INSTITUTION		PATIENT'S NAME																																														
2.	DATE OF INCIDENT	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	IF UNCERTAIN APPROXIMATE DATE: ___/___/___																																														
3.	TIME OF INCIDENT	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> AM/ PM	IF UNCERTAIN APPROXIMATE TIME: ___:___AM /PM																																														
4.	PATIENT'S RN/ OTHER IDENTIFICATION NUMBER : _____ GENDER : MALE / FEMALE / UNKNOWN (please circle)		AGE: _____ ETHNIC: _____ STATUS : ALIVE / DECEASED LANGUAGE BARRIER: YES / NO DIAGNOSIS : _____																																														
5.	TYPE OF PATIENT (please tick one)		DEPARTMENT(S) INVOLVED (please tick)																																														
	<table border="1"> <tr> <td><input type="checkbox"/></td> <td>INPATIENT</td> <td><input type="checkbox"/></td> <td>DAY CARE</td> </tr> <tr> <td><input type="checkbox"/></td> <td>OUTPATIENT</td> <td colspan="2">OTHERS: SPECIFY _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td>A&E</td> <td colspan="2"></td> </tr> </table>	<input type="checkbox"/>	INPATIENT	<input type="checkbox"/>	DAY CARE	<input type="checkbox"/>	OUTPATIENT	OTHERS: SPECIFY _____		<input type="checkbox"/>	A&E			<table border="1"> <tr> <td><input type="checkbox"/></td> <td>MEDICAL</td> <td><input type="checkbox"/></td> <td>O&G</td> <td><input type="checkbox"/></td> <td>ONCOLOGY</td> </tr> <tr> <td><input type="checkbox"/></td> <td>SURGICAL</td> <td><input type="checkbox"/></td> <td>PHARMACY</td> <td><input type="checkbox"/></td> <td>GERIATRIC</td> </tr> <tr> <td><input type="checkbox"/></td> <td>ORTHOPAEDIC</td> <td><input type="checkbox"/></td> <td>RADIOLOGY & IMAGING</td> <td><input type="checkbox"/></td> <td>REHABILITATION</td> </tr> <tr> <td><input type="checkbox"/></td> <td>PAEDIATRIC</td> <td><input type="checkbox"/></td> <td>A&E</td> <td><input type="checkbox"/></td> <td>ICU/ CCU</td> </tr> <tr> <td><input type="checkbox"/></td> <td>LABORATORY</td> <td><input type="checkbox"/></td> <td>PSYCHIATRY</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td colspan="6">OTHERS: SPECIFY _____</td> </tr> </table>	<input type="checkbox"/>	MEDICAL	<input type="checkbox"/>	O&G	<input type="checkbox"/>	ONCOLOGY	<input type="checkbox"/>	SURGICAL	<input type="checkbox"/>	PHARMACY	<input type="checkbox"/>	GERIATRIC	<input type="checkbox"/>	ORTHOPAEDIC	<input type="checkbox"/>	RADIOLOGY & IMAGING	<input type="checkbox"/>	REHABILITATION	<input type="checkbox"/>	PAEDIATRIC	<input type="checkbox"/>	A&E	<input type="checkbox"/>	ICU/ CCU	<input type="checkbox"/>	LABORATORY	<input type="checkbox"/>	PSYCHIATRY	<input type="checkbox"/>		OTHERS: SPECIFY _____				
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OTHERS: SPECIFY _____																																																	
6.	TYPE OF INCIDENT (please tick one)																																																
	<input type="checkbox"/>	Actual	<input type="checkbox"/>	Near Miss																																													
Examples of incidents that need to be reported: (Note that this list is not exhaustive)																																																	
	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																																															
	vi.	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 : _____																																															
7.	BRIEF DESCRIPTION OF WHAT HAPPENED (Please fill in the blanks) The description should explain what happen 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	<input type="checkbox"/>	NONE
	<input type="checkbox"/>	MILD
	<input type="checkbox"/>	MODERATE
	<input type="checkbox"/>	SEVERE
	<input type="checkbox"/>	DEATH
	<input type="checkbox"/>	CURRENTLY CANNOT BE DETERMINED

9. IMMEDIATE ACTION FOLLOWING INCIDENT	
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REPORTED BY

10. DESIGNATION: (please tick one) <table border="1" style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 5%;"><input type="checkbox"/></td> <td>NURSE</td> <td style="width: 5%;"><input type="checkbox"/></td> <td>SPECIALIST</td> </tr> <tr> <td><input type="checkbox"/></td> <td>HOUSE OFFICER</td> <td><input type="checkbox"/></td> <td>PHARMACIST</td> </tr> <tr> <td><input type="checkbox"/></td> <td>MEDICAL OFFICER</td> <td><input type="checkbox"/></td> <td>OTHERS:</td> </tr> </table>	<input type="checkbox"/>	NURSE	<input type="checkbox"/>	SPECIALIST	<input type="checkbox"/>	HOUSE OFFICER	<input type="checkbox"/>	PHARMACIST	<input type="checkbox"/>	MEDICAL OFFICER	<input type="checkbox"/>	OTHERS:	SIGNATURE OF REPORTER: NAME: DATE:
<input type="checkbox"/>	NURSE	<input type="checkbox"/>	SPECIALIST										
<input type="checkbox"/>	HOUSE OFFICER	<input type="checkbox"/>	PHARMACIST										
<input type="checkbox"/>	MEDICAL OFFICER	<input type="checkbox"/>	OTHERS:										

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: <i>Mandatory Root Cause Analysis:</i> 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) <table border="1" style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 5%;"><input type="checkbox"/></td> <td>"PRESCRIPTION SLIP"</td> </tr> <tr> <td><input type="checkbox"/></td> <td>MONITOR THE TREND FIRST</td> </tr> <tr> <td><input type="checkbox"/></td> <td>RCA</td> </tr> <tr> <td><input type="checkbox"/></td> <td>MIRCA (Multi-incident Root Cause Analysis)</td> </tr> </table> Additional comments :	<input type="checkbox"/>	"PRESCRIPTION SLIP"	<input type="checkbox"/>	MONITOR THE TREND FIRST	<input type="checkbox"/>	RCA	<input type="checkbox"/>	MIRCA (Multi-incident Root Cause Analysis)
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<input type="checkbox"/>	RCA								
<input type="checkbox"/>	MIRCA (Multi-incident Root Cause Analysis)								
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:								