AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

Date: _____ Time of Incident: _____

Site Location: _____ Clinician Name: _____

Workplace Incident/Injury/Adverse Event Report

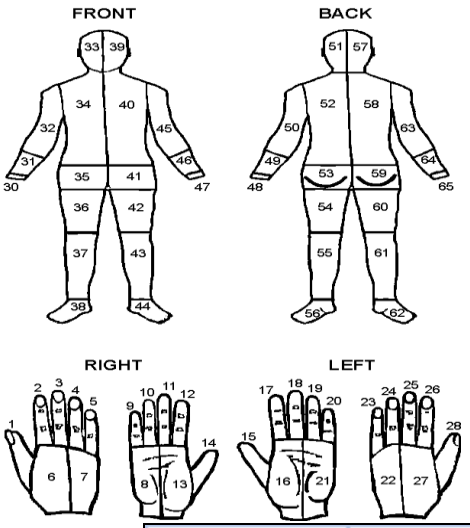
Workplace Injuries, Adverse Events and Occupational Exposure is taken very seriously at Affiliated Physicians and MUST be reported to your department supervisor and Affiliated Physicians Hotline @ 646.535.2318. COMPLETE THOROUGHLY and LEGIBLY.

minor < 18 years old? - ☐Yes ☐No If 'Yes', Parent/Guardian Name & Telephone #: _____

Type of Event: ☐ Flu Vax ☐ COVID Vax ☐ Swab/Test ☐ Wellness ☐Off-Site ☐Office

***Reporter's Name:**	***Reporter's Tel#:**
***Involved Person - first/last NAME**	
***CHIEF COMPLAINT/SYMPTOMS:**	☐Cold☐Clammy☐Pallor☐Diaphoretic ☐Syncope ☐Lightheaded/Dizzy☐Emesis ☐SOB ☐Rash☐Hives ☐Itching☐Swelling☐Fast HR ☐Nausea ☐Headache
***DOB:_ _/_ _/_ _ _ _**	☐Other Symptoms_____
*Sex: ☐ Male ☐ Female ☐ Other	***Allergy History:**
***SIGN-IN# or Appointment #:**	***Telephone #:**

Injury Location: 'x' effected body part



Primary Language	☐English ☐Spanish ☐Russian ☐Chinese ☐Mandarin ☐Other_____
Fluent English	☐Yes ☐No - translator required

TYPE of INCIDENT:

☐Anaphylaxis ☐Vasovagal ☐Anxiety/Panic Attack ☐Syncopal Episode
☐Needle Stick ☐Cut ☐Splash ☐Documentation Error ☐Fall☐Behavior
☐Other Workplace Incident TYPE - explain _____

If Needle Stick:

Source Name & Tel#:_____ ☐source aware

***Complete vaccine administration section below: ☐N/A *date & time of vaccine: _____**

Vaccine	Manufacturer	Lot Number	Route	Body Site	Dose # in Series

***Vital Signs initiated: ☐Y ☐N ☐N/A - If 'Y' – document below *911-EMS activated: ☐Y ☐N ☐N/A**

VS: Time_____ HR_____R_____BP ___/___O2 sat_____**ANA Kit: [every 3-5 min. for Epi]**
VS: Time_____ HR_____R_____BP ___/___O2 sat_____Epi IM ☐ 0.3mL ☐0.15mL ☐0.1mL x ___ [3 doses max]
VS: Time_____ HR_____R_____BP ___/___O2 sat_____Benadryl ☐50mg ☐25mg ☐12.5mg
VS: Time_____ HR_____R_____BP ___/___O2 sat_____Benadryl: ☐IM or ☐Orally | Times _____|_____|_____

Reporter Name: **Reporter Signature:** **Date:**

Clinician Name (Dual confirmed med draw ONLY): Clinician Signature:

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Date: _____ Time of Incident: _____

Site Location: _____ Clinician Name: _____

Involved Person's Name:_____

*Describe incident: [Occurrence and Intervention]

☐VS initiated and monitored closely [at least 2 sets of VSs obtained] ☐EMS activated

*Describe Outcome: [include resolved or lingering symptoms]

☐Symptoms fully resolved prior to leaving event site. Encouraged patient to fu w/ PCP if symptoms return.
☐Patient w/ non-resolving symptoms. Encouraged to seek emergency medical attention if symptoms worsen.
☐Patient made aware to self-monitor for non-resolving symptoms and follow up with PCP for further guidance.
☐Care transferred to EMS at _____[time] ☐Patient declined hospital transfer ☐AMA on file
☐**Other Outcome Details:**
Staff/Reporter Name: **Staff/Reporter Signature:** **Date:**

Witness(s) at time of incident - [Name and Tel#]

_____ | _____

Head Clinician or Site Manager – if applicable ☐N/A

☐I have reviewed and confirmed IR is completed thoroughly and is 100% accurate.

[Name & Signature _____/_____

VAERS reporting: - all serious vaccine-related adverse reactions or vaccine administration errors

VAERS completed? ☐ **Y** ☐ **N/A** **VAERS Report #: _____**

VAERS confirmation # called into Hotline with patient's full name? ☐ **Y** ☐ **N/A**

VAERS Confirmation # sent to compliance@affiliatedphysicians.com? ☐ **Y** ☐ **N/A**

By: _____ Title: _____

Office Use ONLY – Incident Review

Reviewed by: Date:

AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

Date: _____ Time of Incident: _____

Site Location: _____ Clinician Name: _____

Additional Documentation:

Staff/Reporter Name: **Staff/Reporter Signature:** **Date:**

Head Clinician or Site Manager – if applicable - [Name & Signature] –

☐**I have reviewed and confirmed IR is completed thoroughly and is 100% accurate.**

_____/_____

Office Use ONLY – Incident Review

Reviewed by: Date: