**INCIDENT/ACCIDENT REPORT**

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| --- | --- | --- | --- |
| **PERSON INVOLVED**(Last Name) (First Name) (Middle Initial) | * Adult
* Child
 | * Male
* Female
 | Age \_\_\_\_\_\_ |
| Date of Incident/Accident |  | Time of Incident/Accident  | * AM
* PM
 | Exact location of incident/accident |
| Type of Incident/Accident |  |
| * **Client**
 | Client’s Condition Before incident | * Normal
* Confused
 | * Depressed
 | * AM
* PM
 |
| Sedated (Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_ Time of Most recent dose \_\_\_\_\_\_\_\_\_\_\_\_) |
| * **Employee**
 | Department | Job Title | Hire Date |
| * **Visitor**
* **Other**
 | Home Address | Home PhoneCell Phone |
| Occupation | Reason for presence in building |
| * Equipment involved Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Property involved Described: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | Was the person authorized to be in the location of incident/accident? |
| * No
 | * Yes
 |
| Description of exactly happened (how did the incident/accident occur?) |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
| Indicate the Location of injury on diagram below: |
| Vitals:Temp: \_\_\_\_\_\_\_ B/P: \_\_\_\_\_\_\_Pulse: \_\_\_\_\_\_\_O2: \_\_\_\_\_\_\_\_Resp: \_\_\_\_\_\_\_ | Level of Consciousness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Type of Injury:* None apparent
* Abrasion
* Skin Tear
* Laceration
* Hematoma
* Swelling
* Sprain
* Fracture
* Other (Specify below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of Physician Notified | Time Notified  | * AM
* PM
 | Time Physician Responded | * AM
* PM
 |
| Name and relationship of family representative notified | Time Notified | * AM
* PM
 | Time Responded | * AM
* PM
 |
| Seen by Physician? | * No
* Yes
 | If no, Why?  | Where? | Date | Time | * AM
* PM
 |
| First Aid Needed?Type of care provided? | * No
* Yes
 | By whom? | Where? | Date | Time | * AM
* PM
 |
| Taken to the hospital?If yes, which hospital? | * No
* Yes
 | By whom? |  | Date | Time | * AM
* PM
 |
| Name, Title, phone & address of witnesses if applicable | Additional Comments/Notes: |
| **SIGNATURE/TITLE/DATE** | **SIGNATURE/TITLE/DATE** |
| Peron Preparing Report | Medical Director |
| Director of Nursing | Administration Manager |