**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 Phone  Cell 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?) | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | |