INCIDENT REPORT

DATE:			
REPORT COMPLETED BY:			
POSITION:			
NAME OF PROVIDER:			
PHONE:		EMAIL:	

INCIDENT DETAILS

IMPACTED PERSON:	☐ Staff	☐ Participant	☐ Participant's family/Public	☐ Oth
NAME OF IMPACTED PERSON:				
DATE OF INCIDENT:		TIME:		
LOCATION:				

TYPE OF INCIDENT:

☐ Death ☐ serious injury ☐ Violence, abuse, neglect, exploitation or discrimination

☐ Unlawful sexual or physical contact, or assault ☐ Behaviours of concern ☐ Medication error

☐ Unauthorised use of a Restrictive Practice ☐ Property Damage ☐ Equipment failure

☐ Motor vehicle accident ☐ Infectious or hazardous substances ☐ Absconding

DESCRIPTION OF INCIDENT

DETAIL OF HARM CAUSED

INCIDENT FORM

WHERE THERE ANY WITNESSES TO THE INCIDENT ☐ No ☐ Yes If Yes, detail below				
WAS MEDICAL TREATMENT REQUIRED: ☐ No ☐ Yes			WHERE:	
PRACTITIONER DETAILS:				
HAS THIS INCIDENT BEEN REPORTED TO A SUPERVISOR ☐ No ☐ Yes Date:				
NAME:			POSITION:	
PHONE:			EMAIL:	
WERE EMERGENCY SERVICES CALLED: ☐ Ambulance ☐ ☐ Other:				
OTHER PARTIES NOTIFIED: ☐ Guardia ☐ Advocate ☐ Family member ☐ Other:				

ACKNOWLEDGEMENT

I acknowledge that all information included in this incident reports is true and correct.

NAME:	

Signature: _____