INCIDENT/ACCIDENT REPORT

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 ❍ Dining Area ❍ Hallway ❍ Bathroom ❍ Resident's room (No._____) ❍ Other Specify_____

❍ **RESIDENT**
Record diagnosis if contributed to incident/accident:

Resident's condition before incident/accident ❍ Normal ❍ Confused ❍ Disoriented ❍ AM ❍ PM
❑ Sedated (Medication_____ Dose_____ Time of most recent dose_____ Other (Specify)_____

Were bed rails ordered? ❍ No ❍ Yes | Were bed rails present? ❍ No ❍ Yes | If Yes, were bed rails ❍ Up ❍ Down | Was height of bed adjustable? ❍ No ❍ Yes | If Yes, was bed ❍ Up ❍ Down

Was a restraint in use at time of incident/accident? ❍ No ❍ Yes
❑ Physical restraint Type_____ ❑ Chemical restraint Specify_____

❍ **EMPLOYEE** | Department | Job title | Length of time in this position

❍ **VISITOR**
❍ **OTHER**
_____

Home address | Home phone: Cell phone:

Occupation | Reason for presence at this facility

❑ Equipment involved Describe:_____
❑ Property involved Describe:_____

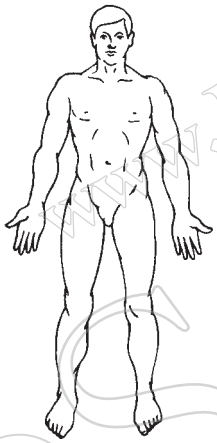
Was person authorized to be at location of incident/accident? No ❍ Yes ❍

Describe exactly what happened, why it happened and what the cause was, if known. If injured, record part of body injured. If property or equipment damaged, describe damage.

Indicate location of injury on diagrams below:

Temp._____ **Pulse**_____ **Resp.**_____

B/P_____



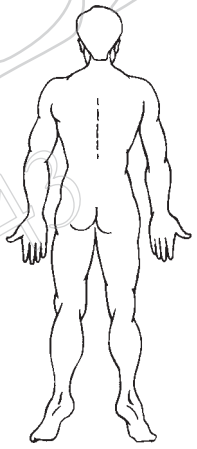
TYPE OF INJURY

1. None apparent ❑
2. Abrasion ❑
3. Skin tear ❑
4. Laceration ❑
5. Hematoma ❑
6. Swelling ❑
7. Burn ❑
8. Sprain ❑
9. Fracture ❑
10. Other (specify below) ❑

_____

LEVEL OF CONSCIOUSNESS

_____



Name of Physician notified | Time of notification ❍ AM ❍ PM | Time Physician responded ❍ AM ❍ PM

Name and relationship of family member/resident representative notified | Time of notification ❍ AM ❍ PM | Time responded ❍ AM ❍ PM

Was person involved seen by a physician? No ❍ Yes ❍ Physician's name | If No, why not? | Where | Date | Time ❍ AM ❍ PM

Was first aid needed? No ❍ Yes ❍ If needed, type of care provided | By whom? | Where | Date | Time ❍ AM ❍ PM

Was person involved taken to a hospital? No ❍ Yes ❍ If Yes, hospital name | By whom? | Manner of transport | Date | Time ❍ AM ❍ PM

Name, title (if applicable), address & phone number of witness(es)

Additional comments and/or steps taken to prevent recurrence

SIGNATURE/TITLE/DATE	SIGNATURE/TITLE/DATE
Person Preparing Report	Medical Director
Director of Nursing/Health Services	Administrator/Manager