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

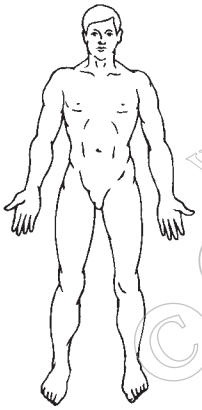
❑ Equipment involved Describe:_____
❑ Property involved Describe:_____

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**_____



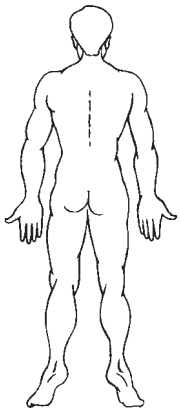
TYPE OF INJURY

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