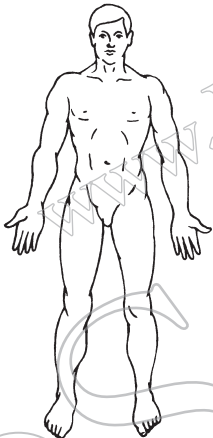
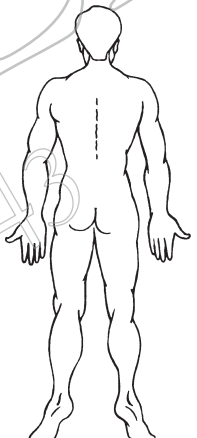


INCIDENT/ACCIDENT REPORT

| | | | | | | | |
|---|--|---|---|--|---|---|---|
| PERSON INVOLVED | | (Last name) | (First name) | (Middle initial) | <input type="radio"/> Adult <input type="radio"/> Child | <input type="radio"/> Male <input type="radio"/> Female | Age _____ |
| Date of incident/accident | Time of incident/accident <input type="radio"/> AM <input type="radio"/> PM | Exact location of incident/accident <input type="radio"/> Dining Area <input type="radio"/> Hallway <input type="radio"/> Bathroom <input type="radio"/> Resident's room (No. _____) <input type="radio"/> Other Specify _____ | | | | | |
| <input type="radio"/> RESIDENT Record diagnosis if contributed to incident/accident: | Resident's condition before incident/accident <input type="checkbox"/> Sedated (Medication _____ Dose _____ Time of most recent dose _____) | | <input type="radio"/> Normal <input type="radio"/> Confused <input type="radio"/> Disoriented | | <input type="radio"/> AM <input type="radio"/> PM Other (Specify) _____ | | |
| | Were bed rails ordered? <input type="radio"/> No <input type="radio"/> Yes | Were bed rails present? <input type="radio"/> No <input type="radio"/> Yes | If Yes, were bed rails <input type="radio"/> Up <input type="radio"/> Down | | Was height of bed adjustable? <input type="radio"/> No <input type="radio"/> Yes | If Yes, was bed <input type="radio"/> Up <input type="radio"/> Down | |
| | Was a restraint in use at time of incident/accident? <input type="radio"/> No <input type="radio"/> Yes | | | | | | |
| | <input type="checkbox"/> Physical restraint Type _____ <input type="checkbox"/> Chemical restraint Specify _____ | | | | | | |
| <input type="radio"/> EMPLOYEE | Department | | Job title | | Length of time in this position | | |
| <input type="radio"/> VISITOR <input type="radio"/> OTHER | Home address | | | | Home phone: _____ Cell phone: _____ | | |
| | Occupation | | Reason for presence at this facility | | | | |
| <input type="checkbox"/> Equipment involved Describe: _____ | | Describe: _____ | | | | Was person authorized to be at location of incident/accident? No <input type="radio"/> Yes <input type="radio"/> | |
| <input type="checkbox"/> Property involved Describe: _____ | | Describe: _____ | | | | | |
| 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 _____ | |
|  | | <p style="text-align: center;">TYPE OF INJURY</p> <ol style="list-style-type: none"> 1. None apparent <input type="checkbox"/> 2. Abrasion <input type="checkbox"/> 3. Skin tear <input type="checkbox"/> 4. Laceration <input type="checkbox"/> 5. Hematoma <input type="checkbox"/> 6. Swelling <input type="checkbox"/> 7. Burn <input type="checkbox"/> 8. Sprain <input type="checkbox"/> 9. Fracture <input type="checkbox"/> 10. Other (specify below) <input type="checkbox"/> | |  | | | |
| LEVEL OF CONSCIOUSNESS | | | | | | | |
| Name of Physician notified | | | | Time of notification <input type="radio"/> AM <input type="radio"/> PM | | Time Physician responded <input type="radio"/> AM <input type="radio"/> PM | |
| Name and relationship of family member/resident representative notified | | | | Time of notification <input type="radio"/> AM <input type="radio"/> PM | | Time responded <input type="radio"/> AM <input type="radio"/> PM | |
| Was person involved seen by a physician? No <input type="radio"/> Yes <input type="radio"/> | | If No, why not? | | Where | | Date | Time <input type="radio"/> AM <input type="radio"/> PM |
| Physician's name and phone number | | | | | | | |
| Was first aid needed? No <input type="radio"/> Yes <input type="radio"/> | | If needed, type of care provided | | By whom? | | Date | Time <input type="radio"/> AM <input type="radio"/> PM |
| Was person involved taken to a hospital? No <input type="radio"/> Yes <input type="radio"/> | | If Yes, hospital name and phone number | | By whom? | | Manner of transport | Date Time <input type="radio"/> AM <input type="radio"/> 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 | | | |