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

❑ Sedated (Medication____________________ Dose__________ Time of most recent dose_________ ❍ AM ❍ PM 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 and phone number	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 and phone number	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

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