INCIDENT/ACCIDENT REPORT

PERSON INVOLVED (Last name)	(First name)	(Middle initial)	❍ Adult ❍ Child	❍ Male ❍ Female	Age _____

Date of incident/accident	Time of incident/accident ❍ A.M. ❍ P.M.	Exact location of incident/accident ❍ Resident's room (No. _____) ❍ Hallway ❍ Bathroom ❍ Dining Room ❍ Other Specify_____

❍ RESIDENT
List diagnosis if contributed to incident/accident:

Alert & Oriented x _____ Check all that apply: ❑ At baseline ❑ New or increased confusion ❑ New medication or treatments in the past 72 hrs.
(describe)_____
❑ Acute change of condition (describe) _____

Contributing factors (e.g., environmental, medical)

❍ 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

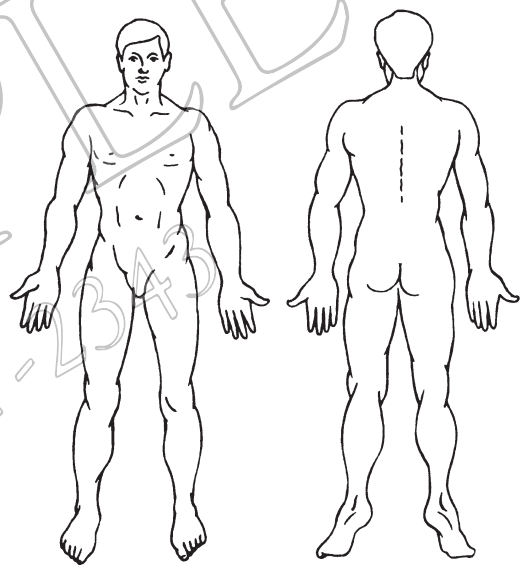
Describe exactly what happened; why it happened; what the causes were. If an injury, state part of body injured. If property or equipment damaged, describe damage.

TYPE OF INJURY

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

LEVEL OF CONSCIOUSNESS

Indicate on diagram location of injury



Vital signs (if applicable) when the resident is supine and at one and three minutes after standing (if unable to stand, use supine to sitting position.

Vital Signs	Initial Incident Supine	One Minute After Standing	Three Minutes After Standing
Temperature			
Pulse			
Respirations			
Blood Pressure			
O_2 Saturation			

Name of Physician notified	Time of notification ❍ A.M. ❍ P.M.	Time Physician responded ❍ A.M. ❍ P.M.
Name and relationship of family member/resident representative notified	Time of notification ❍ A.M. ❍ P.M.	Time Family/rep. responded ❍ A.M. ❍ P.M.

Was person involved seen by a physician? ❍ No ❍ Yes If Yes, physician's name	Where	Date	Time ❍ A.M. ❍ P.M.
Was first aid administered? ❍ No ❍ Yes If Yes, type of care provided and by whom _____	Where	Date	Time ❍ A.M. ❍ P.M.
Was medical intervention beyond first aid required? ❍ No ❍ Yes If yes, was the person involved transferred to a higher level of care? ❍ No ❍ Yes	By whom	Date	Time ❍ A.M. ❍ P.M.

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	Administrator