

Incident Report for Clients

Name of Client:

Date of Incident:

Type of Incident:
 Behaviour of Concern
 Medication
 Accident/Injury/Illness

Property Damage
 Critical
 Other

Time of Incident:

People Involved:

Describe the Incident (Who, What, Where, When, Why, How):

Action Taken/ Employee Follow Up:

Name of Reporter

Signature Below (Requires Actual Signature)

Date

Binder(s):	Adult Services, Family Support Services					Page:	1 of 2
Section(s):	Documentation	A	Mar 30/11	R/R	Oct 17/18		
Program Area(s):	Adult Disability, FSS-Disability						

Was the Guardian Contacted?

Yes
No
N/A

If Yes, by whom:

Form must be completed by hand from this point on

Team Manager Follow Up:

Name of Reporter: _____ **Signature:** _____ **Date:** _____

Coordinator Follow Up:

Name of Reporter: _____ **Signature:** _____ **Date:** _____

Other / Additional Follow Up:

Name of Reporter: _____ **Signature:** _____ **Date:** _____

Program Director/ **Executive Director** **Signature:** _____ **Date:** _____

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