Global
Disability & Health Care Services
1800 009 292

CLIENT INCIDENT REPORT FORM

CONFIDENTIAL

DATE OF INCIDENT& TIME COMMENCING: DATE / /2017 TIME: AM/PM

All incident / injuries involving clients must be reported to the immediate team leader / manager / supervisor as soon as possible and then lodged with General Manager Global head office. This form is to be used to record incidents involving **clients**. **Complete a separate Incident** Report for each client involved in the incident. When you have completed the form forward it to your Team Leader and Global head office. **NOTE: Incidents for Staff, Contractors, Volunteers, and Visitors** are to be recorded on the Global Staff Incident Report Form. For further information refer to the *Incident Management* policy.

1. Personal details of the client:

Client Last Name		**First Name**	
Unit/Home Address			
Unit Email Address:			
Service Provider		Unit:	

2. Incident Event Details

Location of Incident:					
Incident description (Brief Summary)					
What happened immediately prior to the incident? **(Anticedents)**					
What happened during the incident (what and how it happened)					
What was the immediate outcome of the incident?					
If appropriate, what additional events or circumstances over the preceding days/weeks may have also contributed to the incident taking place?					
Location Category	Business Premises ☐ Private Residence ☐ Other Location ☐			**Location** e.g.hall, kitchen	
Date of incident: (dd/mm/yyyy)		**Time of incident**		**Number of Recurrences** in same shift?	
Actions taken to Prevent Recurrence					
Follow up Recommendations					

3. Persons involved (Enter the person details and 'role' for each of the people involved)	
STAFF ON-DUTY at time of Incident	First name Last name Phone No: Position First name Last name Phone No: Position
Reported to Team Leader:	First name Last name Phone No: Position Date Reported: Time Reported:
Reported by (staff member on duty):	First name Last name Phone No: Position Date Reported: Time Reported
Witness	First name Last name Phone No: Address Staff ☐ Contractor ☐ Volunteer ☐ Visitor ☐ Client ☐ Other ☐
First Aid administered by	First name Last name Phone No: Fax No: Address Staff ☐ Contractor ☐ Volunteer ☐ Visitor ☐ Client ☐ Other ☐
Person involved	First name Last name Phone No: Fax No: Address Staff ☐ Contractor ☐ Volunteer ☐ Visitor ☐ Client ☐ Other ☐

4. Injury Sustained Details			
Did the person above sustain injury?	Yes ☐ No ☐	If yes, complete sections 4, 5 refer to policy	
Bodily Location (eg both legs, right arm, left eye, psychological	**Nature of Incident** (eg fracture, burn, laceration)	**Mechanism of Injury** (e.g. Hit by Moving Object / Person)	**Cause of Injury** (e.g. Lifting / Handling, Self, Other Client)

5. First Aid Details			
First aid Administered? Yes ☐ No ☐ (If yes, complete this section)	Date:	Time:	First aid referral: (doctor, hospital etc)
Description of First Aid administered:			

6. Incident Type (Manager only to Complete)		
Incident Type (		

7. Data entered in Incident Register			
Date: / /	**Entered By:**		

INCIDENT FURTHER NOTES & DETAILS

Record sequence of events in time order. Provide additional factual details of the incident.

Sign: Person Reporting Name: Date Time: