DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

INCIDENT REPORT

Care Home: _____ Date: _____

Resident's Name: _____

Date of Incident: _____ Hour: _____

Description of Incident (Include circumstances under which incident occurred):

_____

_____

_____

_____

_____

_____

_____

Final Disposition:

1. Treated by: _____ Ambulance at site? Yes ☐ No ☐
2. To: _____ Yes ☐ No ☐ Via ambulance ☐
   Name of Hospital
   Private car ☐
3. Emergency Room: Treated and Released _____
   Admitted: _____
4. Notified doctor: Yes ☐ No ☐
   Name of doctor: _____ Time: _____
   Orders: _____

_____

_____

_____

_____

_____

5. Notified family: Yes ☐ No ☐
6. **Notified CMA** Yes ☐ No ☐ **Time Notified:** _____**AM / PM**