Horizons Centre
"Maximizing Abilities Through Quality Service"

Medical Incident Report Form

Client Name: _____ Date: _____
Reporter Name: _____ Time of Incident: _____
Location of Incident: _____ Witness: _____

DESCRIPTION OF INCIDENT /TYPE OF INJURY

Write out a chronological description of the incident. (Attach another page if more room is needed.)
It must include the following:

- What Individual was Doing Prior
- Description of the Incident
- Description of Emergency Intervention if Used: _____
- Results of the Action / Incident
- Action Taken by Staff Members

_____
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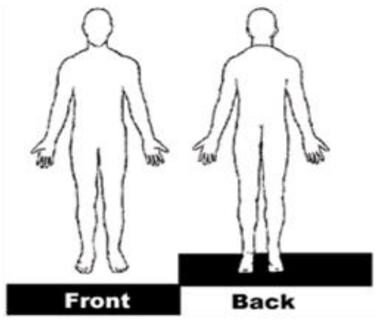

May include but is not limited to:

☐Medication ☐Personal Illness ☐Personal Injury ☐Possible Personal Injury
☐Seizures ☐Other: _____

CONTACT INFORMATION

If the incident required immediate contact or follow up with any of the following, please indicate the name of the contact and the time and date that the contact was made:

	Name	Notified	Date	Copy	Date
Emergency Services:					
Program Coordinator:					
Program Director:					
Executive Director:					
Case Worker:					
Parent/Guardian:					
Caregiver:					
Other (Please specify):					

SIGNATURES

Client _____ Date _____ Coordinator _____ Date _____

Staff _____ Date _____ Program Director _____ Date _____

O H & S COMMITTEE / MANAGEMENT TEAM USE ONLY

Severity of Injury/Illness
(Resulting From A Workplace Incident)
4 ----- 3 ----- 2 ----- 1-----0 (Circle One)

4: Catastrophic (death, serious injury/illness, permanent disability; extensive property damage) 3: Critical (lost time injury illness, temporary disability; considerable property damage 2: Marginal (medical aid injury, minor illness, minor property damage) 1: Negligible (first aid injury; limited property damage) 0: (No Injury, Illness or Property Damage)

Control of Risk Prevention for Future Injury /Illness

_____
_____

_____ _____
Committee Rep/ Management Initials Date