732-300-6289 jenny@eviancare.com

UNUSUAL INCIDENT REPORT FORM

Date of Incident:_________ Time:_______________ AM/PM

Name of person reporting incident (DSP): ____

Date of birth:______________________ Phone number:____

Address of incident:____

Name of person involved in incident:_________________________________ Client/ DSP

Injury:______________ Non-injury;_________________________

Type of Injury:____

Type of non-injury:____

(ex. fire, property damage, abuse, neglect)

Describe the incident in detail. Include what, who, when and how it occured:

____
____
____

What verbal and/or physical interventions were attempted? ____

____

Which action has successfully resolved the incident? ____

____

Was medical attention required? YES / NO   If NO, skip to signatures.

Please explain medical intervention: ____

____

Name of medical professional/hospital involved: ____

Address/Phone: ____

Person reporting incident: Name:___________________________ Signature:_____________________

Position:__________________________ Date:______________________________

Name of the notified party:__________________________________ Relationship___________________

Director/administrator receiving incident report:

Name:__________________________________ Position:___________________________

Signature:____________________________ Date:_________________________________

This form must be completed and returned to Evian Care within 6 hours of incident resolution!