To be completed for ALL incidents and accidents.

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| **REPORTER DETAILS** | | | |
| Name:  Position: | | Phone number:  Date: | |
| **INCIDENT DETAILS** | | | |
| Date:  Time of Incident: AM / PM  Exact location of incident: | | **If you did not see the incident:**  Date you became aware:    Source of information: | |
| **Type of incident:**  Client  Client to client  Client to staff/carer  Staff/carer to client  Client to other  Other to client  Staff workplace incident | **Incident category:**  Actual or alleged abuse, neglect, exploitation  Assault (including threats, unlawful sexual or physical contact)  Actual or alleged sexual misconduct  Unauthorised restrictive practice  Serious Injury  Death  Other staff workplace injury  Hazardous substance  Vehicle accident  Medication mismanagement  Medication misuse  Other | | |
| **DETAILS OF PEOPLE INVOLVED IN INCIDENT** | | | |
| CLIENT  STAFF  OTHER  Full Name:  Gender:  DOB:  Address: | | Injured?  Medical assistance required? | Yes  No  Yes  No |
| ROLE IN INCIDENT: | | | |
| CLIENT  STAFF  OTHER  Full Name:  Gender:  DOB:  Address: | | Injured?  Medical assistance required? | Yes  No  Yes  No |
| ROLE IN INCIDENT: | | | |
| **IF MORE THAN TWO PEOPLE INVOLVED, USE TABLE AT END OF DOCUMENT** | | | |

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| **INJURY (COMPLETE SEPARATE REPORTS FOR EACH INJURED PERSON)** | | |
| **Details of injury:**  Nature of injury/illness (e.g. burn, sprain, cut etc.)  Location on body (please circle and specify): | | |
| **TREATMENT** | | |
| **Was treatment required?**  **Was treatment administered?**  Treatment:  Administered by: | Yes  No  Yes  No | **Comments:** |
| Referral required:  Referred to: | Yes  No |

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| **SUMMARY** | | |
| **Describe how and what happened (please give full details & include a diagram, if appropriate. Use a separate sheet if necessary. Please include car registration number if reporting a Motor Vehicle Accident).** | | |
| **THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY A SENIOR STAFF MEMBER** | | |
| **INITIAL INVESTIGATION** Is this a reportable incident? 🞏 **Yes** 🞏 **No**  **INCIDENT REPORTED TO:**  NDIS Commission Date: Time of notification:  WHS Authority Date: Time of notification:  Police Date: Time of notification:  Coroner Date: Time of notification:  Other Specify: Date: Time of notification: | | |
| **ASSESSMENT SUMMARY** | | |
| Include:  - Persons involved and the context of the incident.  - Actions taken in response to the incident to address safety risks and what will be done to prevent incident from happening again.  - Steps taken to address the client’s wellbeing, safety and support provided.  - Who has been contacted, e.g. family, advocate, police.  - Support provided for clients and staff involved | | |
|  | | |
| NAME: | POSITION: | DATE: |

Attach Investigation Report and communications

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| **DETAILS OF PERSONS INVOLVED IN INCIDENT** | | |
| CLIENT  STAFF  OTHER  Full Name:  Gender:  DOB:  Address: | Injured?  Medical assistance required? | Yes  No  Yes  No |
| ROLE IN INCIDENT: | | |
| CLIENT  STAFF  OTHER  Full Name:  Gender:  DOB:  Address: | Injured?  Medical assistance required? | Yes  No  Yes  No |
| ROLE IN INCIDENT: | | |
| CLIENT  STAFF  OTHER  Full Name:  Gender:  DOB:  Address: | Injured?  Medical assistance required? | Yes  No  Yes  No |
| ROLE IN INCIDENT: | | |
| CLIENT  STAFF  OTHER  Full Name:  Gender:  DOB:  Address: | Injured?  Medical assistance required? | Yes  No  Yes  No |
| ROLE IN INCIDENT: | | |
| CLIENT  STAFF  OTHER  Full Name:  Gender:  DOB:  Address: | Injured?  Medical assistance required? | Yes  No  Yes  No |
| ROLE IN INCIDENT: | | |
| CLIENT  STAFF  OTHER  Full Name:  Gender:  DOB:  Address: | Injured?  Medical assistance required? | Yes  No  Yes  No |
| ROLE IN INCIDENT: | | |