

CRITICAL INCIDENT REPORT

Facility:		Telephone Number:	Date:
Facility Address:		Date of Incident:	Time of Incident:
Facility Administrator:		Person Reporting :	Person in Charge During Incident:
Individuals Involved		Staff Involved	
1. _____		1. _____	
2. _____		2. _____	
3. _____		3. _____	
Incident Type			
<input type="checkbox"/> Unexplained Death	<input type="checkbox"/> Natural Death	<input type="checkbox"/> Accidental Death	<input type="checkbox"/> Suicide
<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Client Self-Abuse	<input type="checkbox"/> Client Injury	<input type="checkbox"/> Client Fall
<input type="checkbox"/> Assaultive Behavior	<input type="checkbox"/> Medical Emergency	<input type="checkbox"/> Medical Complications	<input type="checkbox"/> Seizure
<input type="checkbox"/> Alleged Client Abuse	<input type="checkbox"/> Alleged Client Neglect	<input type="checkbox"/> Alleged Sexual Abuse	<input type="checkbox"/> Fire
<input type="checkbox"/> Alleged Criminal Activity	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Staff Injury	
<input type="checkbox"/> Property Damage	<input type="checkbox"/> Stolen Property	<input type="checkbox"/> Other: _____	
Did Injury Require			
<input type="checkbox"/> Off-Site Medical Care	<input type="checkbox"/> On-Site Medical Care	<input type="checkbox"/> First Aid Care	<input type="checkbox"/> Emergency Service
If on-site medical care was provided, were Universal Precautions used?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Staff or Client injury, was Manager notified immediately?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If damage to agency property, was Manager notified immediately?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were Critical Incident Reporting procedures followed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Incident Description: (Provide facts only, no conclusions or opinions, only who, what, where and when)			
Staff Action in Response to incident:			
Other pertinent Client Information:			
Report Prepared By:		Date:	
Received and Reviewed by:		Comments:	
Reviewer Signature:			
Date:			