Respite Care Program - Incident Report

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| Service Office:  |  |
| Client Involved: |  | Age: |  | Client No.: |  |
| Diagnosis: |  | Physician:  |  |
| Place of Incident: |  |
| Date of Incident: |  **/ /**  | Time: |  |  If home, where: |  |

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| **Drugs Taken within 12 Hours Previous to Incident** |
| **Name of Drug** | **Dose** | **Route** | **Time (am/pm)** | **Administered By** |
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|  |  | **Who was Notified?** |  | **Time** |  | **By Whom?** |
| **Family Notified?** |  Yes |  |  |  |  |  |
|  |  No |  |  |  |  |  |
|  |
| **Physician Notified?** |  Yes |  |  |  |  |  |
|  |  No |  |  |  |  |  |
|  |
| **Service Offices Notified?** |  Yes |  |  |  |  |  |
|  |  No |  |  |  |  |  |
| **Action Taken By Physician:**  |
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| Describe the incident and/or injuries (if any). If none, state "No apparent injuries." Report action taken by client, employee and physician. |
| As Observed by Agency Employee: |  |  |
| As Reported by Agency Employee: |  |  |
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| Was employee injured in the incident? |  Yes |  No |
| Was Worker’s Compensation filed? |  Yes |  No |
| Was the incident reported to insurance carrier? |  Yes |  No |

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| Witnesses: |  |
| Date of Report: |  | Time: |  |  |
| Reported by: |  | *(Include Name and Job*  |
| Report Completed by: |  | *Classification)* |
| Director’s Signature: |  | Date:  |  |

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| **This Incident Report is to be completed in case of accident, illness or death of a client while being served by Agency staff. Within 24 hours, send copy of this report to the ADS Respite Care Program Specialist and retain a copy in the client's file.** |