

Name
ACC Claim #:



Incident Form

Use this form to report injury, illness, accident or other event.

Complete all relevant sections.

The incident relates to: <i>(tick one)</i> <input type="checkbox"/> Client <input type="checkbox"/> Staff Member <input type="checkbox"/> Other <i>(specify)</i>			
Name of Affected Person(s):		Date of Incident:	Time of Incident:
Affected Person's Address:		Affected Person's D.O.B.:	Gender: <i>(please tick)</i> <input type="checkbox"/> Female <input type="checkbox"/> Male
Location of Place of Work: <i>(client's home address if appropriate)</i>		Particulars of Employer: Mclsaac Caregiving Agency Ltd PO Box 302437 North Harbour Auckland 0751 Ph: (09) 414 4530 Fax: (09) 414 4570	

INCIDENT DETAILS

Incident Type: <input type="checkbox"/> Near miss <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Other	Severity of Incident: <input type="checkbox"/> Minor (first aid less than 1 day off work) <input type="checkbox"/> Moderate (Doctor and/or 1-5 days off work) <input type="checkbox"/> Serious (see "Serious Harm" definition) <input type="checkbox"/> Potentially serious <input type="checkbox"/> Unknown at this stage	Treatment Details: <input type="checkbox"/> None <input type="checkbox"/> Physio <input type="checkbox"/> First aid <input type="checkbox"/> Hospital <input type="checkbox"/> Nurse <input type="checkbox"/> Other providers
What happened?		
What do you think caused or contributed to the incident?		
What action did you take?		

Turn over to complete page two

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State date and time incident reported to Area Supervisor*

Date:

Time:

* Reportable events must be reported within 8 hours. Serious events within 4 hours. Sentinel events within 1 hour (see Incident/Accident Policy for definition of these events).

Your Name:

Position:

Date:

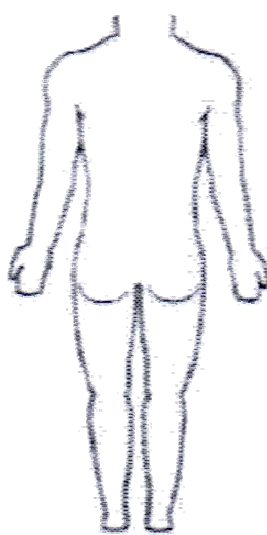
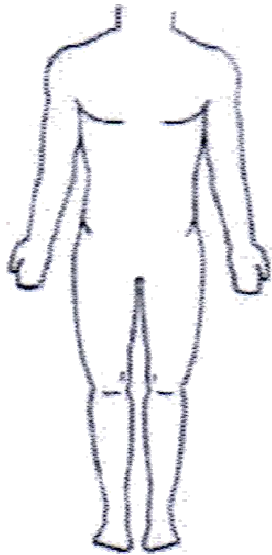
What was your role in the event?

Signature:

Area Supervisor Only - Have you completed an investigation? Yes No

INJURY DETAILS

Body Part: (shade the part of the body that is injured) Left Right



Injury Type: (please tick)

- | | | |
|--|--|---|
| <input type="checkbox"/> Aches/Pain (gradual/sudden) | <input type="checkbox"/> Cut (infected/not infected) | <input type="checkbox"/> Strain/Sprain |
| <input type="checkbox"/> Bruising (minor) | <input type="checkbox"/> Dental injury | <input type="checkbox"/> Other (e.g. verbal abuse, sexual harassment) |
| <input type="checkbox"/> Burn/Scald | <input type="checkbox"/> Dermatitis | |
| <input type="checkbox"/> Chemical reaction | <input type="checkbox"/> Foreign body | |
| <input type="checkbox"/> Physically assaulted | <input type="checkbox"/> Being pushed/shoved | <input type="checkbox"/> Serious harm |
| <input type="checkbox"/> Pressure sore area | <input type="checkbox"/> Hyper reflexia | (Complete Serious Harm form) |

Was there a significant hazard involved? Yes No

OFFICE USE ONLY: List action taken.