2018
NDIS

# CLIENT INCIDENT FORM

## National Premier Disability Services

ADMIN | 0416 855 097

**Document Control**

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**CLIENT INCIDENT FORM**

*(please complete all the details below and attach all relevant documentation)*

NAME OF CLIENT:

.....

ADDRESS OF CLIENT:

.....

CLIENTS HOME PHONE NUMBER: .....

EMPLOYEE NAME: .....

TELEPHONE NAME: ..... JOB TITLE: .....

**DETAILS OF INCIDENT: (where applicable please tick appropriate box)**

WERE YOU A WITNESS? YES ( ) NO ( )

WHEN DID THE INCIDENT OCCUR?

DAY: ..... DATE: ..... TIME ..... AM/PM

WHERE DID THE INCIDENT OCCUR?

.....

.....

.....

WHAT WERE THE CIRCUMSTANCES?

.....

.....

.....


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DID THE INCIDENT OCCUR DUE TO AN OHS ISSUE? (if yes please give details) YES ( ) NO ( )

.....

.....

**CLIENT INCIDENT REPORT (CONT.)**

WAS FIRST AID TREATMENT PROVIDED? YES ( ) NO ( ) (if yes please give details)

WAS MEDICAL TREATMENT PROVIDED? YES ( ) NO ( ) (if yes please give details)

ACTION TAKEN:

.....

.....

.....

DID THE CLIENT REQUIRE AN AMBULANCE? YES ( ) NO ( )

DID YOU CALL AN AMBULANCE FOR THE CLIENT? YES ( ) NO ( )

DID THE CLIENT GO TO THE HOSPITAL? YES ( ) NO ( )

**OR**

DID THE CLIENT WISH TO VISIT THEIR GP?

.....

DID YOU REPORT THE INCIDENT TO THE NURSING CARE COORDINATOR AS SOON AS THE INCIDENT OCCURED?

.....

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WOULD YOU LIKE TO SCHEDULE A DEBRIEF WITH YOUR NURSING CARE COORDINATOR?
YES ( ) NO ( )

FURTHER ACTION TO BE TAKEN? YES ( ) NO ( )

ADDED TO CQI/OHS MEETING AGENDA YES ( ) NO ( )

**EMPLOYEE SIGNATURE: .....**

**DATE: .....**


Contact Us

National Premier Disability Services

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