Department of Health
Client Incident Report Form

Please turn this form immediately into your Regional Coordinator/Program Manager once completed

(To be completed by Clients in the event of an incident involving the service provided, public safety, an injury, or damage to property)

Name of Client Involved (Print):

Department:

Regional Coordinator:

List name/addresses/phone numbers of witnesses to the incident:

PRIMARY DETAILS OF INCIDENT

Date of Incident Occurrence: Time:

☐ Yes ☐ No **Injury to client?**

Has client's next-of-kin or contact person been notified? ☐ Yes ☐ No

Were the RCMP or fire department notified?

☐ Yes, Who: ☐ No

Incident Details

What were you doing? _____

Where were you? _____

What happened? _____

_____

_____

_____

CLIENT CONTACT INFORMATION: First Name: _____ Last Name: _____

Address: _____ Phone: _____ Email: _____

_____

_____

Client's Signature: _____ Date: _____

☐ more on reverse side

SUPERVISOR ASSESSMENT AND FOLLOW-UP

Support for affected client been arranged? ☐ Yes ☐ No

Interventions to prevent incident re-occurrence? ☐ Yes ☐ No

Copied to Manager for further reporting? ☐ Done ☐ No

Supervisor's follow-up statement: _____

_____

Supervisor's Signature: _____ Date: _____