LENDING A HAND HOME CARE

INCIDENT REPORT/ ALL INCIDENTS MUST BE REPORTED WITHIN 12HRS

Name of Individual filing report: _____ Date of report: ____/____/_____

Date of Incident: _____ Time of Incident: _____ ☐ am ☐ pm

Name of Participant: _____

Nature of Complaint: _____

Location of Incident: _____

List full names and phone contact number of Individuals directly involved:

Clients ***Staff***

_____ _____

_____ _____

List full names and phone numbers of witnesses: (If applicable)

_____

_____

_____

Summary of FACTS (be specific – do not include opinions or speculations). **Use back of form if more space needed.**

_____

_____

Follow-up action taken so far: _____

_____

Further follow-up required: ☐ Yes ☐ No Date Due: _____

Reporter's Signature: _____ **Date:** _____

Dept. Director's Signature: _____ **Date:** _____

TOTAL QUALITY MANAGEMENT COMMITTEE:

Are follow-up actions completed? ☐Yes ☐No
If yes, staple follow-up report to this form.
If no, please explain and give date for completion. _____

If the incident happened after normal business hours or on the weekend, please call 267-506-4635!