

RESIDENTIAL CHOICE

(CM Provider)

INCIDENT REPORT

Client's Name: _____

Foster family/ARCH
Operator: _____

Date of Incident: _____ Time of Incident: _____

Type of Incident: Fall _____ Medication Error _____ Property Damage _____

Client's condition prior to incident: Oriented _____ Disoriented _____

Other (Specify) _____

Who was present: _____

Where incident occurred: Bedroom _____ Bathroom _____

Other (Specify) _____

What happened: (Describe briefly) _____

Description of injury/side effects: _____

Final Disposition:

1. Treated by: _____

Ambulance at site? Yes _____ No _____

2. To: _____ Yes _____ No _____ Via ambulance _____ Private Car _____
Name of Hospital

3. Emergency Room: Treated and Released _____ Admitted: _____

4. Notified Doctor: Yes _____ No _____

Name of Doctor: _____ Time: _____

Orders: _____

Care giver Signature

Date

Please notify case manager of any incidents requiring medical treatment.