



Client Incident Report

Client Information

Client Name:	Phone:
Address:	City:
State: Zip:	
Date of Report:	Time of Report: <input type="checkbox"/> AM <input type="checkbox"/> PM
Name of Person Completing Report:	Title:
Did Incident occur on company premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Comfort Keepers Employee Information

Employee Name:	Job Title:
Address:	City:
State: Zip:	Supervisor's Name:
Date Reported to Supervisor:	Time Reported to Supervisor: <input type="checkbox"/> AM <input type="checkbox"/> PM

Incident Information

Type of Incident: <input type="checkbox"/> No Injury <input type="checkbox"/> Medical <input type="checkbox"/> Fall <input type="checkbox"/> Fatality <input type="checkbox"/> Property Loss <input type="checkbox"/> Other (explain)	
Date of Incident:	If lost item,
Time of Incident: <input type="checkbox"/> AM <input type="checkbox"/> PM	Date Item last seen:
	Time Item last seen: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Date Item 1st noticed missing:
	Time Item 1st noticed missing: <input type="checkbox"/> AM <input type="checkbox"/> PM
Emergency Contact Person Notified <input type="checkbox"/> Yes <input type="checkbox"/> No	Date & Time of Contact: <input type="checkbox"/> AM <input type="checkbox"/> PM
Name of Emergency Contact:	Relationship to Client:
911 Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client Transported To:
Did Client refuse medical attention: <input type="checkbox"/> Yes <input type="checkbox"/> No	When did injury occur: Time:

Description of Incident (*describe the sequence of events that caused incident*)

Describe lost or damaged item:

Witnesses to Incident? Yes No, Explain:

CK Administrative Use Only

Other Follow up Action Taken:

What can/will be done to prevent this type of incident?

Employee Signature:

Date:

Supervisor Signature:

Date:

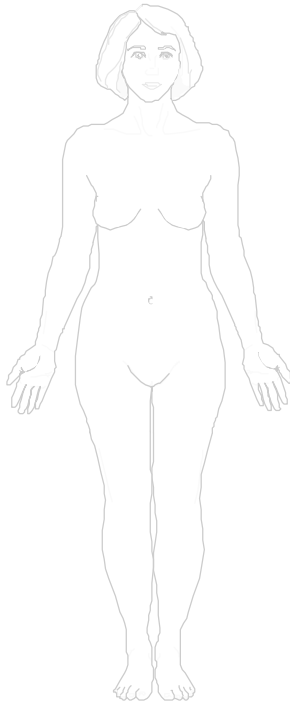
Diagram Completed By: _____ **Date:** _____

Indicate on Diagram the location(s) of Injury, if any:

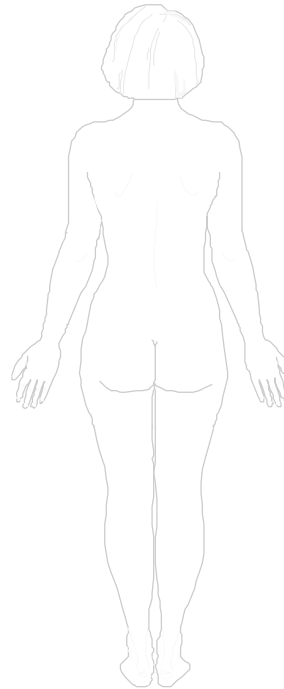
- 1. Laceration (Cut)
- 2. Bite
- 3. Abrasion (Scrape)
- 4. Burn

- 5. Bruise
- 6. Scratch
- 7. Bump
- 8. Open Fracture

9. Other – specify



Front



Back

Was Client conscious? Yes No

Was the Client confused or acting different? Yes No

Did the Caregiver come in contact with Bodily Fluids? Yes No

Additional Notes:
