WEST LIMERICK INDEPENDENT LIVING CLG
Sheehan's Rd, Newcastle West, Co. Limerick
TEL: 069 77320 or 069 77952
Email: info@limerickcil.com

Incident - Accident - Near Misses - Report Form

Fill in all blanks and boxes that apply.

Name of Employee: _____ Phone: _____

Address of Client's Residence: _____

Client's Name: _____ Sex: M F Birth date: ___/___/___ Incident Date: ___/___/___

Time of Incident: ___:___am/pm Witnesses: _____

Name of Next of Kin Notified: _____ Notified by: _____ Time Notified: ___:___am/pm

EMS (911) or other medical professional ☐Not notified ☐Notified Time Notified: ___:___am/pm

Location where incident occurred: ☐Bedroom ☐Bathroom ☐Hall ☐Kitchen ☐Living room
☐ Dining room ☐ Stairway ☐Gym ☐ Office ☐ Unknown ☐ Other (specify) _____

_____

_____

Equipment / Product involved: ☐ Sliding Board ☐ Hoist ☐ Wheelchair ☐ Bed
☐ Walking Aid ☐ Standing Frame ☐ Other Equipment (specify):_____

_____

Cause of Injury (describe): _____

☐ Fall to surface; Estimated height of fall ___feet; Type of surface: _____

☐ Fall from tripping ☐ Fall from wheelchair ☐ Injured by object ☐Eating or choking

☐ Insect sting/bite Animal bite ☐ Exposure to cold

Other (specify):_____

Describe specifically how the injury happened. _____

_____

_____

_____

_____

_____

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Parts of body injured: ☐ Eye ☐ Ear ☐ Nose ☐ Mouth ☐ Tooth ☐ Part of face ☐ Back

☐ Part of head ☐ Neck ☐ Arm ☐ Wrist ☐ Hand ☐ Leg ☐ Ankle ☐ Foot ☐ Trunk

Other (specify): _____

First aid given at the facility (e.g. comfort, pressure, elevation, cold pack, washing, bandage): _____

_____

Treatment provided by: _____

- ☐ No doctor's or dentist's treatment required
- ☐ Treated as an outpatient (e.g. office or emergency room)
- ☐ Hospitalized (overnight) # of days: _____

Number of days of limited activity from this incident: _____ Follow-up plan for care of the client: _____

_____

_____

Corrective action needed to prevent reoccurrence: _____

_____

_____

_____

Name of Service Coordinator/Official notified: _____

Signature of Staff Member: _____ Date: _____

Signature of Client/Next of Kin: _____ Date: _____

Signature of Witness: _____ Date: _____