QUEST support

Our Mission To provide quality services which enhance the lives of people with disabilities.

Incident Report

Date of Incident: _____ Time: Start _____ End _____

Supported Person Involved: _____ Staff Reporting: _____

Location of Incident: _____ Staff Involved _____

_____

Type of Incident

- ☐ Medical
- ☐ Accident
- ☐ Injury
- ☐ Medication
- ☐ PRN (OTC)
- ☐ PRN (Prescription)
- ☐ Physical Behavior
- ☐ Verbal Behavior
- ☐ Self Abuse
- ☐ AWOL
- ☐ Other (specify) _____
- ☐ Substance Abuse

Description of Incident

Describe What Happened (Provide specifics about the Type of Incident identified above)

What Happened That Triggered The Behavior (Document anything that may have caused the behavior to occur)

What Was Staff's Initial Response (Describe staff's initial response, outcomes from the behavior, and follow-up required)

phone 403 381 9515 fax 403 320 6555
www.questsupport.com

1245 2nd Ave S, Box 1201 Stn Main
Lethbridge, AB T1J 4A4

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Was a Restrictive Procedure Used ☐ Yes ☐ No Who Authorized: _____

If "Yes" describe:
- ☐ PRN (Medication and Dose) _____
- ☐ Restraint (Physical) _____
- ☐ Restricted Access (Items/Activities/People/Etc) _____
- ☐ Other (Specify) _____

Who Has Been Notified

☐ Management ☐ Team Leader ☐ Staff Responsible ☐ Guardian ☐ Family

☐ Doctor ☐ Pharmacist ☐ Police/Ambulance ☐ Other (specify) _____

What Instructions Were Given: (Describe any instructions given, and by whom)

_____

_____

_____

_____

_____

Signature

Staff: _____ (Print Name) _____ (Signature) _____ (Date)

Administration: _____ (Print Name) _____ (Signature) _____ (Date)

Office Use Only

Comments/Follow-up/Recommendations

_____

_____

_____

_____

☐ **Home** ☐ **PDD (Critical)** ☐ **Guardian** ☐ **Med Record** ☐ **Record** ☐ **File**

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