



CRITICAL INCIDENT REPORT *For*

UNLICENSED HOMES AND COMMUNITY INCLUSION ACTIVITIES *and*
LICENSED HOMES FOR INCIDENTS NOT REPORTABLE TO LICENSING

GENERAL INFORMATION

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Name of Residence / Service / Activity

Phone Number

Address

City/Town

Postal Code

Name of Service Provider

PERSON(S) INVOLVED

Supported Individual Visitor Other (please specify)

F M

Name of Person

Birthdate
(YYYY/MM/DD)

Gender

List All Person(s) Adversely Affected:
(attach list if necessary)

TYPE OF INCIDENT – REPORTABLE TO CLBC

<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Medication Error	<input type="checkbox"/> Use of Seclusion
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Sentinel Event	<input type="checkbox"/> Motor Vehicle Accident	<input type="checkbox"/> Exclusionary Time Out
<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Use/Poss of Weapon	<input type="checkbox"/> Aggressive/Unusual Behavior	<input type="checkbox"/> Communicable Disease
<input type="checkbox"/> Financial Abuse	<input type="checkbox"/> Use/Poss of Illicit Drug	<input type="checkbox"/> Missing/Wandering Person	<input type="checkbox"/> Infection Control
<input type="checkbox"/> Neglect	<input type="checkbox"/> Fall	<input type="checkbox"/> Use of Restraint	<input type="checkbox"/> Bio Hazard Accident
<input type="checkbox"/> Death	<input type="checkbox"/> Disease/Parasites	<input type="checkbox"/> Other Injury	
<input type="checkbox"/> Poisoning	<input type="checkbox"/> Unexpected Illness	<input type="checkbox"/> Service Delivery Problem	

DETAILS OF INCIDENT

Date of Incident
(YYYY/MM/DD)

Time of Incident

Location of Incident

What Occurred (attach additional page if required):

Disclaimer

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the Community Living Authority Act and/or the Freedom of Information and Protection of Privacy Act (FOIP Act). Under certain circumstances, the collected information may be subject to disclosure as per the FOIP Act. Any questions about the collection, use or disclosure of this information should be directed to the Director, Information, Privacy and Records Services Branch (250)387-0820, PO Box 9702, Stn Prov Govt, Victoria, BC V8W 9S1



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Action Taken:

NOTIFICATION

Family	<input type="checkbox"/> Y <input type="checkbox"/> N	Date (YYYY/MM/DD)	Time	Licensing	<input type="checkbox"/> Y <input type="checkbox"/> N	Date	Time
			()	Fire Department	<input type="checkbox"/> <input type="checkbox"/>		
Name	Relationship	Phone Number		Police	<input type="checkbox"/> <input type="checkbox"/>		
Person In Charge Notified:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> n/a			Coroner	<input type="checkbox"/> <input type="checkbox"/>		
Health Care Provider Notified:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> n/a			Other (Specify)	<input type="checkbox"/> <input type="checkbox"/>		

Name of Person Reporting Incident	Position	Signature	Date (YYYY/MM/DD)	Time
Name of Witness/Attending Staff	Position	Signature	Date (YYYY/MM/DD)	Time
Name of Supervisor	Position	Signature	Date (YYYY/MM/DD)	Time

(Rev June 2009)

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