Rainbow Home Healthcare
Better Health For Independent Living

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INCIDENT REPORT

Instruction: Please complete this form immediately after you or your client has an accident during the time which he or she is under your care. If you need more space, use the back.

Reporting Employee Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone#: _____

Incident Date: _____ Time: _____

Incident Report Date: _____ Time: _____

Location of Incident: _____

Type of Incident - Please check in the box:

Medical Emergency	
Unexpected Serious Illness	
Accident Requiring Physician Treatment	
Hospitalization	
Fire	
Law Enforcement Agency	
Death	
Other	

Describe in detail how and what happened: _____

_____

_____

_____

_____

_____

_____

_____

Resolution of Incident: _____

_____

_____

_____

_____

Signature of Reporter: _____ Date: _____