RESIDENTIAL ALTERNATIVES COMMUNITY CARE PROGRAM

_____
(CM Provider)

INCIDENT REPORT

Client's Name:_____

Foster family/ARCH Operator:_____

Date of Incident:_____Time of Incident:_____

Type of Incident: Fall_____ Medication Error_____ Property Damage_____

Client's condition prior to incident: Oriented _____ Disoriented _____

Other (Specify) _____

_____

Who was present:
_____

Where incident occurred: Bedroom _____ Bathroom _____

Other (Specify) _____

_____

What happened: (Describe briefly)
_____

_____

_____

Description of injury/side effects: _____

_____

Final Disposition:

1. Treated by:_____

An ambulance at site? Yes_____ No_____

2. To:_____Yes___ No___ Via ambulance___ Private Car____
Name of Hospital

3. Emergency Room: Treated and Released _____Admitted:_____

4. Notified Doctor: Yes_____ No_____

Name of Doctor:_____Time:_____

Orders:_____

_____

_____
Care giver Signature Date

Please notify case manager of any incidents requiring medical treatment.

Mr."D"