QUEST support

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

Incident Report

Date of Incident: _____ Supported Person: _____

Time: Start _____ hrs., End _____ hrs. Staff Reporting: _____

Location of Incident: _____ Staff Involved: _____

_____

Type of Incident (Check all that apply)

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

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
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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: _____

☐ PRN (Medication and Dose): _____

☐ Restraint (Physical): _____

☐ Restricted Access (Items/Activites/People/Etc.): _____

☐ Other (Specify): _____

Who Has Been Notified

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

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

Is The Incident Likely To Reoccur (before the next business day)***?***

☐ No ☐ Yes (If "Yes" describe the instructions given should the incident recur)

Instructions Given: (Describe any instructions given, and by whom, should the incident recur)

_____

_____

_____

_____

_____

Signature:

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

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

Office Use Only

Comments/Follow-up/Recommendations:

_____

_____

_____

_____

_____

☐ **Guardian** ☐ **PDD (Critical)** ☐ **Doctor (Psych/Family)** ☐ **File**

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