

INCIDENT REPORT FORM

Is it a reportable incident? Yes No

PART A. REPORTER DETAILS

Full Name:

Position:

Contact Number:

Email:

PART B. INCIDENT DETAILS

Name of person involved in the incident:

Role of involved person Staff Participant Visitor Volunteer Contractor

Date of Incident:

Time of Incident:

Location of Incident:

Type of Incident Hazard Near-miss Incident Concern/ Change

INVOLVED PERSON DETAILS

Full Name:

Date of Birth:

Gender:

Home Address:

Contact Number:

WITNESS DETAILS (If applicable)

Full Name:

Contact Number:

Email:

Full Name:

Contact Number:

Email:

INCIDENT (Describe what happened before and during the incident)

INCIDENT REPORT FORM

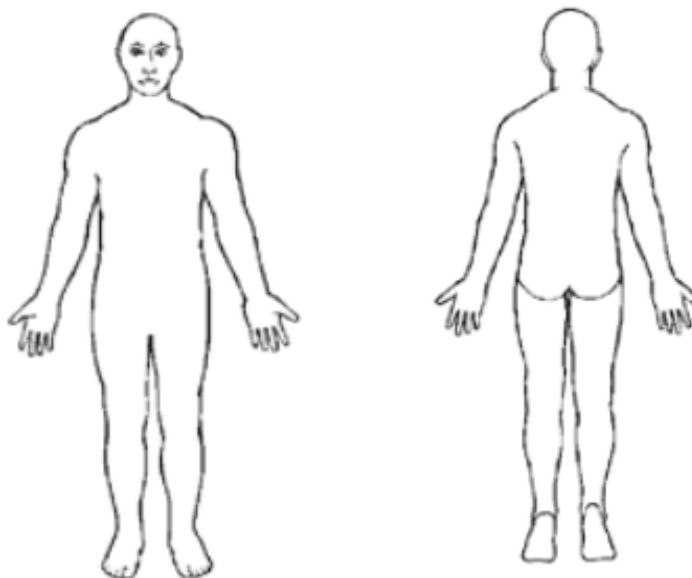
DAMAGE DETAILS (Describe any damages and to what extent)

CAUSE OF INJURY

<input type="checkbox"/> Manual Handling	<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> Behaviour of Participant / Staff	<input type="checkbox"/> Contact with animal
<input type="checkbox"/> Drugs / alcohol	<input type="checkbox"/> Electric Shock	<input type="checkbox"/> Equipment Malfunction	<input type="checkbox"/> Exposure to Hazardous substance
<input type="checkbox"/> Fall / trip / slip	<input type="checkbox"/> Infection Exposure	<input type="checkbox"/> Involuntary movement of Participant	<input type="checkbox"/> Psychological Stress – Bullying/Harassment
<input type="checkbox"/> Psychological Stress - Person	<input type="checkbox"/> Psychological Stress – Workload or Organisation	<input type="checkbox"/> Sun exposure	<input type="checkbox"/> Transport Accident

Other

INJURY DETAILS (Describe and list nature of injury and its location)



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IMMEDIATE ACTION TAKEN (List any treatment done)

SUGGESTED FURTHER ACTION

(Include suggestions for reducing or eliminating the issue & timelines)

HAS THE FOLLOWING PERSON/AGENCY BEEN NOTIFIED

Details (Date)

Next of Kin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
Emergency Contact	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
Support Manager	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
Police	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
NDIS Commission	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	

SUGGESTED FURTHER ACTION

(Include suggestions for reducing or eliminating the issue & timelines)

Declaration

Name and Signature of Reporter:

Date:

*Note: Forward Incident Report Form Immediately to Support Manager

INCIDENT REPORT FORM

Incident Investigation

To be filled by Support Manager

Date received:
Type of Incident <input type="checkbox"/> Hazard <input type="checkbox"/> Near-miss <input type="checkbox"/> Incident <input type="checkbox"/> Concern/Change
Name of Staff:
Name of participant involved:

Short-Term Responses

Action/resolution of the issue and feedback to the worker is required immediately if urgent, within 2 days if the situation requires a prompt response and within 5 days for others. Indicate action taken by Support Manager: (include discussion & feedback with employee, client/carer) to resolve the issue or provide an interim resolution.

Signed by:	Date:
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Response Timeframe

<input type="checkbox"/> Immediate	Urgent	Date:
<input type="checkbox"/> Within 2 days	Prompt response required	Date:
<input type="checkbox"/> Within 5 days	Other matters	Date:

Risk Identified

Did the incident occur as part of the involved person's normal activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Did equipment contribute?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Was the equipment used designed for activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Was the equipment properly maintained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Did the equipment fail?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Had a risk assessment been undertaken?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Did safety instructions accompany the activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Were the SWP followed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Was appropriate Personal Protective Equipment (PPE) used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Was the involved person trained in this activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Did a known behaviour problem contribute?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Did poor housekeeping contribute?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Did the work environment contribute?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

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After reviewing the above prompts and undertaking interviews and/or site visits, what are the identified cause(s) of the injury?

Remedial Actions Recommended

<input type="checkbox"/> Conduct task analysis	<input type="checkbox"/> Reinstruct person(s) involved	<input type="checkbox"/> Improve design / construction / guarding	<input type="checkbox"/> Conduct hazard systems audit
<input type="checkbox"/> Develop and/or provide training	<input type="checkbox"/> Develop / review task procedures	<input type="checkbox"/> Provide debriefing and/or counselling	<input type="checkbox"/> Improve communication / reporting procedures
<input type="checkbox"/> Improve work environment	<input type="checkbox"/> Request maintenance	<input type="checkbox"/> Improve security	<input type="checkbox"/> Review WHS policies / programs
<input type="checkbox"/> Improve personal protection	<input type="checkbox"/> Temporarily relocate person involved	<input type="checkbox"/> Provide or replace equipment / tools	<input type="checkbox"/> Provide, review or replace Behaviour Support Plan
<input type="checkbox"/> Housekeeping review	<input type="checkbox"/> Improve work organisation	<input type="checkbox"/> Investigate safer alternatives	<input type="checkbox"/> Request Safety Data Sheet
<input type="checkbox"/> Other			

What has been implemented or planned to prevent recurrence?

Long-Term Responses

If further action is required, outline this and include timelines for review/resolution:

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Outcomes			
Did the injured person stop work?	<input type="checkbox"/> No <input type="checkbox"/> Yes – date and time:		
<input type="checkbox"/> Treated by doctor	<input type="checkbox"/> Lodged workers compensation claim	<input type="checkbox"/> Contacted by Return to Work Coordinator	<input type="checkbox"/> WorkCover notified
<input type="checkbox"/> Insurer notified	<input type="checkbox"/> Returned to normal duties	<input type="checkbox"/> Returned to modified duties	<input type="checkbox"/> Hospitalised
<input type="checkbox"/> WHS committee / representative notified	<input type="checkbox"/> Reassessment required (If yes, completed and filed with this report)	<input type="checkbox"/> Issue, action/outcome entered in client file	<input type="checkbox"/> Issue reduced
<input type="checkbox"/> The incident recorded in the Incidents Register	<input type="checkbox"/> Issue resolved	<input type="checkbox"/> The incident recorded in the Incidents Register	<input type="checkbox"/> The incident recorded in the Violent Incidents Register
<input type="checkbox"/> Other			
Support Manager's review comments:			
Full Name:		Signature:	
Position:		Date:	