Accident incident Report Form

Staff incident/accident/ near miss report

STATEMENT BY PERSON INVOLVED IN THE INCIDENT

Full Name: .....WorkCover Claim Yes/No
Job Title: .....Time Lost Yes/No.
Department/ Ward/ Unit:.....
Exact Location at which Incident Occurred:.....

Date of Incident: ...../...../20..... Time of Incident: am/pm

Describe the sequence of events leading up to and including the incident

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..

Other person(s) involved

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.

Witnesses

.....
..

Other forms completed: Patient/Visitor Yes/No - Name: Drug Error Yes/No

INCIDENT DETAILS (Please circle)

Type of Incident		**Nature of Injury**	**Part of Body Injured**	
Trip, slip,fall	Patient handling	None	Head	Eyes
Car,bike	Lift/Lower	Burn	Abdomen	Thigh
Splashed	Pushing/Pulling	Infection	Trunk	Leg
Hit,punched	Caught In	Foreign Body	Back	Shoulder
Sharps	Exposure	Sprain/strain	Arm	Neck
Faulty items	Stepped on, into	Bruising, crush	Finder	Feet
Allergy	Struck by object	Laceration	Hand	Ankle
Stress	Electrical	Fracture	Wrist	Internal
Other	Fire	Abrasion	Other	None

Side of Body Hurt ☐ Left side ☐ Right side

Is this a recurrence of a Previous Injury ☐ YES ☐ NO If yes, give details

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TREATMENT

Type

☐ None ☐ Treatment at Casualty ☐ Treatment by Medical Practitioner ☐ First Aid by non-medical staff

Name of Person Administering Treatment

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Treatment Given

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EMPLOYEE COMMENTS / RECOMMENDATIONS

Contributing factors - (Unsafe acts / conditions)

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Action required to prevent recurrence

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