POLICY TYPE: HEALTH AND SAFETY STANDARDS
(HSS) POLICY TITLE: *CRITICAL AND NON-CRITICAL INCIDENT REPORTING*

APPENDIX 12: *SIVA CRITICAL INCIDENT REPORT FORM*

SIVA supporting individuals through valued attachments

CRITICAL INCIDENT REPORT FORM

SIVA supporting individuals through valued attachments

AGENCY INFORMATION	NAME OF SERVICE PROVIDER OR AGENCY		FACILITY / LICENCE NUMBER IF APPLICABLE	
	ADDRESS CITY POSTAL CODE		PHONE NUMBER	
	NAME OF MANAGER		DATE OF BIRTH DAY Mth Yr	SEX ☐ M ☐ F
PERSONS INVOLVED	NAME OF PERSON IN CARE (1)		DATE OF BIRTH DAY Mth Yr	SEX ☐ M ☐ F
	NAME OF PERSON IN CARE (2)		DATE OF BIRTH DAY Mth Yr	SEX ☐ M ☐ F
	NAME OF PERSON IN CARE (3)		NUMBER OF PERSONS IN CARE AFFECTED	
	☐ STAFF ☐ VISITOR ☐ OTHER (SPECIFY)			

TYPE OF INCIDENT

	REPORT OF		REPORT OF		REPORT OF
PHYSICAL ABUSE	☐	DISEASE OUTBREAK	☐	SERVICE DELIVERY PROBLEMS	☐
SEXUAL ABUSE	☐	DEATH	☐	AGGRESSIVE / UNUSUAL BEHAVIOR	☐
EMOTIONAL ABUSE	☐	FALL	☐	MISSING / WANDERING	☐
NEGLECT	☐	MOTOR VEHICLE INJURY	☐	MEDICATION ERROR	☐
FINANCIAL ABUSE	☐	OTHER INJURY	☐	ATTEMPTED SUICIDE	☐
UNEXPECTED ILLNESS	☐	POISONING	☐	EMERGENCY SAFTEY INTERVENTION	☐

SPECIFIC DETAILS OF INCIDENT

DATE OF INCIDENT TIME OF INCIDENT LOCATION OF INCIDENT

PLEASE BE SPECIFIC (ATTACH ADDITIONAL SHEETS IF NECESSARY)

NOTIFICATION

CONTACTED	YES	NO
☐ PARENT	☐	☐
☐ NEXT OF KIN	☐	☐
☐ LEGAL GUARDIAN	☐	☐

DATE _____ TIME _____ PHONE NUMBER _____

NAME OF PERSON CONTACTED

NOTIFIED	YES	NO	*DATE*	*TIME*	***NOTIFIED***	YES	NO	*DATE*	*TIME*
HEALTH CARE PROVIDER	☐	☐			**LICENSING / MHO**	☐	☐		
AMBULANCE	☐	☐			**MANAGER**	☐	☐		
POLICE	☐	☐			POLICE	☐	☐		
MCF	☐	☐			**FIRE DEPARTMENT**	☐	☐		
OTHER(SPECIFY)	☐	☐							

SEQUENCE OF EVENTS PRECEDING AND FOLLOWING INCIDENT

CAUSE & CONTRIBUTING FACTORS

(ATTACH ADDITIONAL SHEETS IF NECESSARY)

IMMEDIATE ACTION TAKEN

SIGNATURES	NAME	POSITION	SIGNATURE	DATE	TIME
WITNESS/ ATTENDING STAFF					
FORM COMPLETED BY					
LICENCEE/ MANAGER					

REVIEW FOLLOWUP

DATE _____ REVIEWED BY _____

RECOMMENDATIONS _____

SIGNATURE _____