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| --- | --- |
| 1. Name of facility:

Health **REPORT OF INCIDENT OR DEATH AT FACILITY** |  |
| 1. Address of facility:
 |  |
| 1. Tel no:
 |  |
| 1. Name of Senior manager of facility:
 |  |
| 1. Contact details of Senior manager:
 |  |
| 1. Date of incident:
 |  |
| 1. Name of patient/client:
 |  |
| 1. DOB:
 |  |
| 1. Folder Number (if applicable)
 |  |
| 1. Incident witnessed by (if applicable):
 |  |
| 1. Report written by: (should be most senior person)
 |  |
| 1. Medical History of patient/client:
 |  |
| 1. Medication:
 |  |
| 1. Description of condition and activities of deceased for the 24 hours preceding the death:
 |  |
| 1. Description of incident or death: (include who was present, what was observed, any interventions and outcomes of these interventions, as well as times of these)
 |  |
| 1. Signature:
 | Date of report: |