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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: |