Form 13 - State Medical Needs Shelter Incident Report Form

Shelter location: _____ Date/Time of Incident:_____@_____am/pm

□ Resident □ Visitor □ Staff
Other:_____

Name:_____
DOB:_____

Address:_____

Phone Numbers: Home #:_____ Cell: #_____

Detailed Description of Incident:
_____
_____
_____
_____
_____
_____
_____

Vital Signs:
BP_____HR_____R_____

Recommendations:
_____
_____
_____

Follow-Up:
_____
_____
_____

Was injured seen by a medical provider? □ Yes □ No
Name of medical provider/hospital: _____ Phone Number: _____
Additional Comments:
_____
Facility/Nurse Manager Notified: Date:_____ Time:_____
Submitted to SMNS Coordinator Date:_____ Time:_____
Person Preparing Report:

Name/Title: _____ Date: _____

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Official Use Only