

Incident Report Form

My Choice Support Care



Type of incident

Is it a reportable incident?

☐ Yes

☐ No

If Yes, reportable to:

☐ NDIS

☐ Other Authorities _____

Name of staff member providing report

Names of witnesses: *(if applicable)*

Report relates to:

☐ Hazard

☐ Near-miss

☐ Incident

☐ Concern/Change

Date and time of when issue/incident occurred or was noticed:

Location / Address:

Name of Client:

Description of issue being reported: *(sketch if required)*

Immediate action taken: *(if applicable)*

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Suggested further action: *(include suggestions for reducing or eliminating the issue & timelines)*

Reported to:
(Name of Manager/Coordinator)

Date:

Signed by:
(Name of Staff Member)

Date:

***Note:** Forward Incident Report Form Immediately to Manager/Coordinator

Incident Investigation

Date received at head office:

Report relates to: ☐ Hazard ☐ Near-miss ☐ Incident ☐ Concern/Change

Name of employee:

Name of client:

Short-Term Responses

Action/resolution of the issue and feedback to the worker is required immediately if urgent, within 2 days if the situation requires a prompt response and within 5 days for others.

Indicate action taken by Unit Manager/Coordinator: (include discussion & feedback with employee, client/carer) to resolve the issue or provide an interim resolution.

Signed by:

Date:

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Response Timeframe

- | | | |
|--|-------------------------------------|-------|
| <input type="checkbox"/> Immediate | Urgent | Date: |
| <input type="checkbox"/> Within 2 days | Prompt response required | Date: |
| <input type="checkbox"/> Within 5 days | Relatively prompt response required | Date: |

Long-Term Response

If further action is required, outline this and include timelines for review/resolution:

- | | |
|--|---|
| <input type="checkbox"/> Reassessment required
(If yes, complete and file with this report) | <input type="checkbox"/> Issue, action/outcome entered in client file |
| <input type="checkbox"/> Issue reduced | <input type="checkbox"/> Incident has been recorded in the Incidents Register |
| <input type="checkbox"/> Issue resolved/eliminated | <input type="checkbox"/> Incident has been recorded in the Violent Incidents Register |

Manager/ Coordinator:

Signature:

Date:

Reported to the Health and Safety Committee:

☐ Yes ☐ No



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☐ Yes ☐ No