



This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes. This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident. This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER		EMAIL ADDRESS	PHONE NUMBER
NAME OF RESIDENCE		ADDRESS OF RESIDENCE	
INCIDENT INVOLVES RESIDENT(S) IN: <input type="checkbox"/> PRIVATE PAY <input type="checkbox"/> PUBLICLY SUBSIDIZED	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY <input type="checkbox"/> FRASER <input type="checkbox"/> INTERIOR <input type="checkbox"/> NORTHERN <input type="checkbox"/> VANCOUVER COASTAL <input type="checkbox"/> VANCOUVER ISLAND		

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

1	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
2	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
1	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	<input type="checkbox"/> STAFF <input type="checkbox"/> OTHER (SPECIFY)	
2	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	<input type="checkbox"/> STAFF <input type="checkbox"/> OTHER (SPECIFY)	

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	TRANSFER TO HOSPITAL <input type="checkbox"/> YES <input type="checkbox"/> NO	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)			
<input type="checkbox"/> Attempted suicide by a resident <input type="checkbox"/> Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner) <input type="checkbox"/> Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported) <input type="checkbox"/> Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication) <input type="checkbox"/> Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson) <input type="checkbox"/> Missing person <input type="checkbox"/> Police call <input type="checkbox"/> Other (specify)			
EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)			
IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)			

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
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