



A Reportable Incident must be reported to the Assisted Living Registry within 24 hours of the incident. Please review Section 51 and Schedule E of the Assisted Living Regulation. This form must be completed in full by staff who witnessed the event. Use one form per incident. Completed forms can be faxed to (250) 953-0496 or sent by email to Hlth.assistedlivingregistry@gov.bc.ca

Residence Information and Site Manager Contact			
Residence			Phone Number
Address of Site		City	
Name of Site Manager		Email	Phone Number
Incident Involves: <input type="radio"/> Private Pay Resident <input type="radio"/> Publicly Subsidized Resident <input type="radio"/> Resident Receiving Per Diem Funding	Health Region <input type="radio"/> Fraser <input type="radio"/> Northern <input type="radio"/> Interior <input type="radio"/> Vancouver Coastal <input type="radio"/> Island	Classification <input type="checkbox"/> Seniors and Persons with Disabilities <input type="checkbox"/> Mental Health <input type="checkbox"/> Supportive Recovery	
Persons Involved (if more than 2 residents or 2 witnesses are involved, attach a separate sheet with the additional names)			
Last Name of Resident Affected	First Name of Resident Affected	Date of Birth (dd/mm/yyyy)	Gender <input type="radio"/> M <input type="radio"/> F <input type="radio"/> X
Last Name of Resident Affected	First Name of Resident Affected	Date of Birth (dd/mm/yyyy)	Gender <input type="radio"/> M <input type="radio"/> F <input type="radio"/> X
Last Name of Witness	First Name of Witness	<input type="radio"/> Staff <input type="radio"/> Other (specify) <input type="radio"/> Resident	
Last Name of Witness	First Name of Witness	<input type="radio"/> Staff <input type="radio"/> Other (specify) <input type="radio"/> Resident	
Incident Details			
Date of Incident (dd/mm/yyyy)	Time <input type="radio"/> AM <input type="radio"/> PM	Transfer to the Hospital <input type="radio"/> Yes <input type="radio"/> No	Where did incident take place? (e.g. resident's unit, common area)
Notification to Resident's Contact Person <input type="radio"/> Yes <input type="radio"/> No - provide reason:		Name of Person Notified	Relationship to Resident
Notification to Funding Program (if applicable) <input type="radio"/> Yes <input type="radio"/> No - provide reason			
Type of Incident (tick all applicable boxes)			
<input type="checkbox"/> Aggression between residents	<input type="checkbox"/> Emotional abuse	<input type="checkbox"/> Motor vehicle injury	<input type="checkbox"/> Police call
<input type="checkbox"/> Aggressive or unusual behaviour	<input type="checkbox"/> Fall	<input type="checkbox"/> Neglect	<input type="checkbox"/> Service delivery problem
<input type="checkbox"/> Attempted suicide	<input type="checkbox"/> Financial abuse	<input type="checkbox"/> Other injury	<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Choking	<input type="checkbox"/> Food poisoning	<input type="checkbox"/> Overdose	<input type="checkbox"/> Unexpected illness
<input type="checkbox"/> Death (see below)	<input type="checkbox"/> Medication error	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Disease outbreak or occurrence	<input type="checkbox"/> Missing person	<input type="checkbox"/> Poisoning	
If Death was checked above, was the Coroners Service notified? <input type="radio"/> Yes <input type="radio"/> No - provide reason			

Incident Description

The person who witnessed the event must describe in detail what they observed. (attach a separate sheet if necessary)

Immediate Action Taken by Staff Following Incident

(attach a separate sheet if necessary)

Signatures

Name of Staff who Witnessed and/or Responded to the Incident

Name of the Residence Manager or Delegate

Date (dd/mm/yyyy)