BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

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 https://www2.gov.bc.ca/assets/gov/health/forms/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 953-0496.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER

NAME OF RESIDENCE	ADDRESS OF RESIDENCE	CITY

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☐ PRIVATE PAY ☐ PUBLICLY SUBSIDIZED	☐ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ 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 ☐ M ☐ F
2	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER ☐ M ☐ F
1	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	
2	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
	☐ AM ☐ PM	☐ YES ☐ NO	

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ 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)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☐ Police call
- ☐ Fall resulting in hospitalization
- ☐ Disease outbreak
- ☐ 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)

PRINT CLEAR FORM