

## Accident Injury Incident Report

*This form is to be used to report any accident or incident that has, or may have, caused harm. Fill out as much of the form as you can.*

**PART A – must always be completed**

**PART B – must be completed if someone is hurt**

**PART C – must be completed if another vehicle is involved**

### PART A – Advise details of incident and involved parties

Incident Type			
INCIDENT TYPE		PERSON CONCERNED	
<input type="checkbox"/> Injury	<input type="checkbox"/> Property Damage	<input type="checkbox"/> Staff	<input type="checkbox"/> General Public
<input type="checkbox"/> Illness	<input type="checkbox"/> Near Miss	<input type="checkbox"/> Visitor	<input type="checkbox"/> Other :
<input type="checkbox"/> Threat / Security	<input type="checkbox"/> Death	<input type="checkbox"/> Service User	
<input type="checkbox"/> Vehicle	<input type="checkbox"/> WHS	<input type="checkbox"/> Volunteer	
<input type="checkbox"/> Assault	<input type="checkbox"/> Other		

1. Details of person completing form			
Person completing this form		Phone	
Person receiving report			
Person assigned to investigate			

2. Details of person concerned			
Full Name (Print)			
Phone		Mobile	

**Please advise names and contact phone numbers of any other persons involved:**

**Please provide name & contact numbers of any witnesses**

### 3. Description of Incident/ Injury/ Near Miss

Date occurred		Time occurred		Date and time reported	
Did the accident / injury / incident occur		Onsite <input type="checkbox"/>	Offsite <input type="checkbox"/>	Moving Vehicle <input type="checkbox"/>	
Exact Location:					
Activity being performed at time of incident:					
Describe in full of what occurred: <i>(please attach an extra sheet if necessary)</i> :					
Do you think there were contributing causes (e.g. autumn leaves on the footpath that made it slippery)?					
Do you think the accident / injury / incident could have been avoided?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, what would need to have been done to avoid it.					
Sketch or provide any other information:					

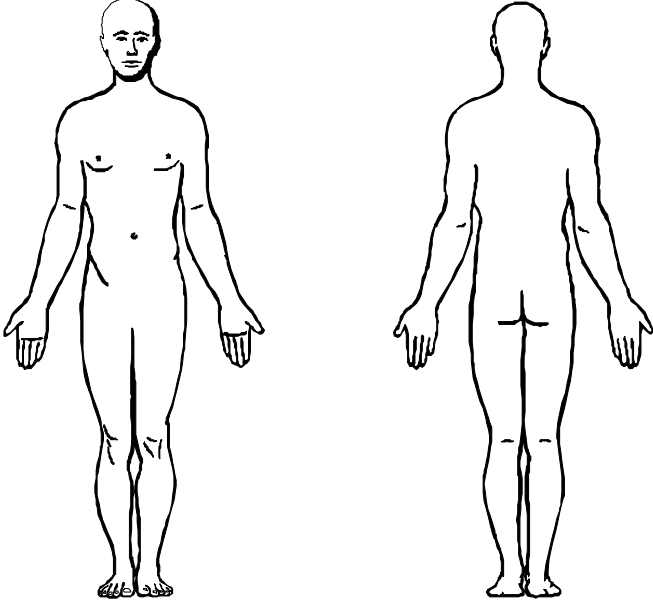
If you are ONLY completing Part A sign here otherwise continue to part B

Person competing report		Person receiving report	
Name		Name	
Signature		Signature	
Position		Position	
Date		Date	

**PART B – To be completed ONLY when an Injury or Illness has occurred**

1. Details of person concerned			
Full name:		Phone	
Nature of Injury / Illness			
Mental State at time of injury/illness			

Please mark on diagram where and what symptoms the person displayed

	MARK LETTERS ON RELEVANT PARTS OF THE BODY		LOCATION	
	Abrasions	A	Head	
	Bleeding	B	Facial	
	Burns	Bn	Chest	
	Confusion	C	Abdomen	
	Deformity	D	Arm	
	Fracture	F	Leg	
	Laceration	L	Hand	
	Pain	P	Knee	
	Swelling	S	Foot	
	Tenderness	T	Spinal	
	Rash	R	Shoulders	
	Other			

2. OBSERVATIONS AND ASSESSMENTS			
<b>CONSCIOUS</b>		<b>BREATHING</b>	
<input type="checkbox"/> Alert	<input type="checkbox"/> Confused	<input type="checkbox"/> Unconscious	<input type="checkbox"/> Giddy
<input type="checkbox"/> Drowsy			
		<input type="checkbox"/> Rapid	<input type="checkbox"/> Slow
		<input type="checkbox"/> Shallow	<input type="checkbox"/> Absent
		<input type="checkbox"/> Wheeze	<input type="checkbox"/> Gasping
		<input type="checkbox"/> Unremarkable	
<b>REFERRED To:</b>	<input type="checkbox"/> Hospital in Ambulance	<input type="checkbox"/> Driven to Hospital	<input type="checkbox"/> Driven to Doctor
Was First Aid provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Person providing First Aid (name)			
Assessment (Describe the injury/symptoms you observed, and the actions taken)			

### 3. HISTORICAL INFORMATION

Other Signs & Symptoms (incl. past medical history if known):

Their GP's Name

If Not seen by their GP – name of GP the person saw

Date they saw GP

Time they saw GP

Is it a recurring injury ?

Yes

No

If Yes, date of previous injury

Other comments (Outcome of Consultation)

### 4. NOK details

Next of Kin  
Notified

Yes  No

Date

Time

How?

Who Was  
Notified

Relationship

What did the person notified do?

If you are only completing Part A & B sign here otherwise continue to part C

Person completing report		Person receiving report	
Name		Name	
Signature		Signature	
Position		Position	
Date		Date	

**PART C - To be completed ONLY when vehicle involved**

1. Were the Police called?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:		Time:
Who called them:		Which Station		
Who was spoken to?				
Name of Police Officer who attended:				

2. Our vehicle and Driver details	
Name of Driver with our service:	Vehicle Rego:

3. Other Vehicle and Driver details			
Name of other driver (driver No 1)			
Driver 1's street address			
Phone		Mobile	
Licence No (Driver 1)		Vehicle Rego (Driver 1)	
Insurance details (driver 1)		Vehicle Model (Driver 1)	
Description of Driver 1's Vehicle (make, colour and identifying features)			

Name of other driver (driver No 2)			
Driver 2's street address			
Phone		Mobile	
Licence No (Driver 2)		Vehicle Rego (Driver 2)	
Insurance details (driver 2)		Vehicle Model (Driver 2)	

Description of Driver 2's Vehicle (make, colour and identifying features)	
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**4. Action Taken**

<b>Please select from list any action that was taken by staff or other present</b>	<input type="checkbox"/> Verbal redirection <input type="checkbox"/> Called Ambulance <input type="checkbox"/> Given First Aid <input type="checkbox"/> Physically removed <input type="checkbox"/> Restrained	<input type="checkbox"/> Called Police <input type="checkbox"/> Sent to Hospital <input type="checkbox"/> Sent to Doctor <input type="checkbox"/> Consulted Supervisor
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Describe action taken including strategies to minimise further incident:

**Please sign below if Part C has also been completed**

Person completing report		Person receiving report	
<b>Name</b>		<b>Name</b>	
<b>Signature</b>		<b>Signature</b>	
<b>Position</b>		<b>Position</b>	
<b>Date</b>		<b>Date</b>	