Incident Report Form

RTO 22360 CRICOS 03612C

Incident Details

Date of Incident				
Time of Incident				
Incident Reported by				
Name of person completing this form				
Office Address			State	
Incident type	**Critical**		**Non-critical**	
Sub-Type	Serious Injury		Injury	
	Hazard		High Potential Incident	
	Property Damage		Near Miss	
	Challenging Behaviours		Notifiable Incident	

Details of injured person

Name:				Contact number:			
Address:				Date of Birth:			
Employee:	Yes		No	Gender:	Male	Female	
Emergency Contact Details							
Name:				Contact number:			
Relationship				Contacted?	Yes	No	

Description of Incident

Describe the incident – please provide as much detail as possible
Who was involved?
What caused the incident to happen? (Contributing factors)
Did anyone witness the incident? - please provide name(s) and contact details.
What could prevent it from happening again?

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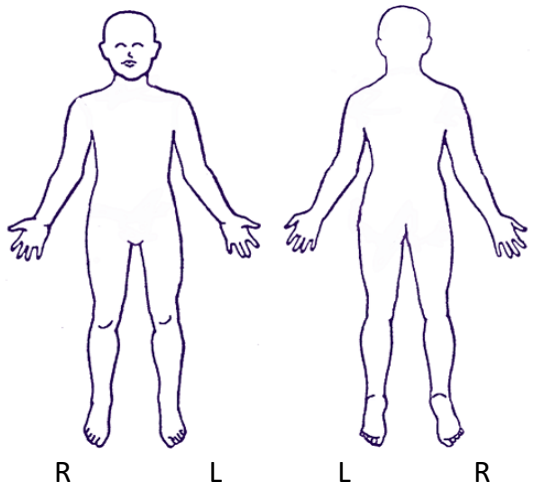
Immediate Action Taken:

Observation		First Aid- please complete the following page	
Immobilisation		Emergency Services	
Returned to normal duties		Sent Home	
Sent to Doctor		Sent to hospital	

First Aid Treatment:

Consent to treatment		Refusal of treatment		Time First Aid Commenced:	
Casualty signature:					
First aid assessment: DRSABCD					

General Observations (Insert Number)								**Assessment Injuries/Symptoms & Signs**
Conscious State 1. Fully conscious 2. Drowsy 3. Unconscious								Abrasion Discolouration Pain Bleeding Fracture (?) Sprain Burn Laceration Swelling Contusion Tenderness
Pulse 1. Slow, 2. Rapid, 3. Strong, 4. Weak, 5. Regular, 6. Irregular								
Pulse Rate								
Respiration 1. Deep, 2. Shallow, 3. Absent, 4. Gasping, 5. Rapid, 6. Slow								
Respiration Rate								
Temperature (^{O}C)								
Skin 1. Hot 2. Warm, 3. Cool, 4. Cold								
Pupils:								
	Reactive	**R**	**L**	**R**	**L**	**R**	**L**	
	Equal							

R L L R

Allergies/ Medications/Past Medical History:
Treatment:

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Illness Type:

First Aid Treatment		Medical Treatment		Lost Time Injury/Illness*	
Non-work-related illness		Fatality			
*Resulting in more than one whole day or one whole shift away from work.					
Own Transport		Time of Departure		Expected Destination	
Ambulance		Time of call		Who called		Time arrived	
To own Doctor		Time of Departure			
Other (e.g. Police, Security)		Service		Time of call		Who called		Time arrived	
Continue Event		Time continued		Who advised	
First Aider (Print Name):				Date:	
Signature:				Time:	

Academic Coordinator: (Include follow up to incident & action to prevent reoccurrence- if applicable)

Academic Coordinator Name:	
Academic Coordinator Signature:	
Date:	

OFFICE INSTRUCTION:
Scan and save completed form to VDrive – General Storage - VFA Data\Compliance\Incidents\Incident Reports
File original in students file