Incident / Accident Report Form

Date	Time	Location

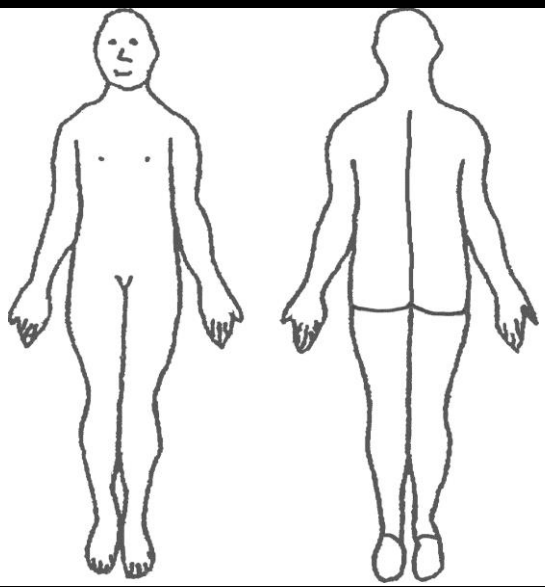
Victims Name	Date of Birth	Gender
		M / F

Address

Explain how the injury happened and your observations?

Observations	Time
Level of Consciousness	
Fully Conscious	
Drowsy	
Unconscious	

Assessment - indicate area of injury



Treatment given

Is there any recommendations to reduce risk of injury happening again?

Have you de-briefed and reported this within your workplace?

Please ensure privacy is ensured to patient by following these 3 steps
1. Original to file 2. Copy to Doctor/Ambulance 3. Copy to casualty if requested

Follow Up/Referral	Comments
☐ Ambulance	
☐ Medical Centre	
☐ Parents/Guardian	
☐ Other	

First Aider Name (Print):	Signature: