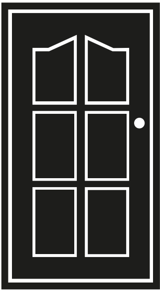

Clinical Incident

PORTFOLIO NUMBER			
CLIENT GIVEN NAME			
CLIENT SURNAME			
SEX		DOB	

Date of Incident Time of Incident Location of Incident

Date and Time the incident was reported to the Yellow Door office

Who did the incident affect? Client Staff Both Other

Type of Incident Accident Near miss Fall Medication error Other

Description

Describe what happened

Analysis

What contributed to the incident/accident/near miss/fall/medication error?

Did any injury/harm result from incident? (If so, please describe below, and action taken)

Prevention

What action has been taken to prevent reoccurrence?

Signed by Staff Member Date

Details of Witness if applicable

OFFICE USE ONLY

Give this incident an identifying number

Was this incident raised at a Clinical Meeting? Yes No

Was the incident reported to the GP / Family / Referring Organisation? Yes No

Plan for Resolution? Measurements taken to mitigate the risks of the incident reoccurring Yes No

Staff Member Date

Write below if any further information is required