

**AOI Client** Accident/ Incident Report Form

Name of Aide/Attendant: \_\_\_\_\_

Name of Client \_\_\_\_\_

AOI program (IHSS, PCW, ILST, CNA, Skilled Nursing): \_\_\_\_\_

Date of occurrence: \_\_\_/\_\_\_/\_\_\_                      Time of the occurrence: \_\_\_\_\_ am-pm

Location of the occurrence: \_\_\_\_\_

Witness Present? (name and phone number): \_\_\_\_\_

Type of Incident (mark all that apply)

<input type="radio"/> Suspected Abuse	<input type="radio"/> Suspected Neglect	<input type="radio"/> Suspected Exploitation
<input type="radio"/> Law enforcement Involvement	<input type="radio"/> Environmental hazard involvement	<input type="radio"/> Emergency services involvement
<input type="radio"/> Client Injury/Fall	<input type="radio"/> Medication error	<input type="radio"/> Other

Please provide a brief description of the event:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What action was taken? \_\_\_\_\_

Who has been notified of this incident?:

<input type="radio"/> Protective services	<input type="radio"/> Family/Guardian
<input type="radio"/> Department of Public Health and Environment	<input type="radio"/> Law Enforcement
<input type="radio"/> AOI Staff	

Were services able to continue following the event?    \_\_\_ Yes    \_\_\_ No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_