GOOD FAMILY SUPPORT SERVICES

Critical Incident Report Form

Date & Time of Report

Reported By

Position/Title of Reporter

Contact Information

Participant Information

Name

Date of Birth

Admission ID (if known)

Primary Street Address

City & State

Zip Code

Primary Language

Location of Incident

Date of Incident

Time of Incident

Summary of Incident

GOOD FAMILY SUPPORT SERVICES

Type of Incident: (Check all that apply)

- Injury
- Medication Error
- Abuse/Neglect
- Property Damage/Loss
- Service Interruption
- Other: [Please specify]

  ____

Immediate Actions Taken:
(Please provide a detailed account of the incident, including what led up to the incident, the incident itself, and the immediate response.)

Immediate Actions Taken:
(Describe any immediate actions taken in response to the incident, such as first aid, contacting emergency services, securing the area, etc.)

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Witnesses:
(List any witnesses to the incident, including their names and contact information, if available.)

Injuries:
(Describe any immediate actions taken in response to the incident, such as first aid, contacting emergency services, securing the area, etc.)

- Were there any injuries as a result of the incident? [ ] Yes [ ] No
- If yes, please describe: ____

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Notifications:
(Indicate who has been notified about the incident, such as family members, DHS, DOH, MCO SCE, supervisor, etc.)

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Additional Information:
(Indicate who has been notified about the incident, such as family members, DHS, DOH, MCO SCE, supervisor, etc.)

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Follow-Up Actions Required:
(Outline any follow-up actions that may be required, such as medical care for the participant, further investigation, repair of damages, etc.)

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6715 OGONTZ AVE PHILADELPHIA, PA 19138
215-849-4744
INFO@GFSSHOMECARE.COM

GOOD FAMILY SUPPORT SERVICES

Signature of Reporting Administrative Staff Member/Caregiver: ______________________________

Date: ________________

Supervisor/CIMC Review and Comments: ____

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Signature of Supervisor/CIMC: ____

Date: _________________

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