

Hill Country Care Providers
CLIENT RELATED EVENT

Client Name: _____ Date of Incident:

Address: _____ Time:

Telephone: _____

Location _____ of _____ Incident:

Describe the injury or illness in detail and indicate the part of the body affected: _____

Describe fully how the incident occurred and what you were doing: _____

Equipment
Involved: _____

Any Witnesses: Yes No If YES; Name and Phone # of
Witness: _____

Seen by Physician: Yes No If YES; Name and Phone # of
Physician: _____

Taken to Hospital: Yes No If YES; Name of
Hospital: _____

Admitted: Yes No **If YES; Room No:**

Form Completed by: {Signature} Name {printed} and Title Date

Staffing Coordinator

RN Supervisor