



Hamilton

Residential Care Facility
FORM 3 – REPORT OF OCCURRENCE OF
ASSAULT, INJURY OR DEATH

Details

Name of RCF:

Address:

Date of Occurrence: DD/ MM/ YYYY **Time:** HH:MM ☐ AM ☐ PM

Name of Resident:

Date of Birth: DD/ MM/ YYYY **Gender:** ☐ Male ☐ Female ☐ Other

Date of Admission: DD/ MM/ YYYY

**Name of person/s who
discovered or observed
occurrence:**

**Brief description of
occurrence:**

**Type of injury sustained, if
any:**

Was First Aid given? ☐ Yes ☐ No Describe:

Was 911 called? ☐ Yes ☐ No Time:

Was Resident sent to hospital? ☐ Yes ☐ No Hospital:

**Were relatives or friends
notified?** ☐ Yes ☐ No Who:

Was the Physician notified? ☐ Yes ☐ No Time:

Name of Physician:

Physician notified by:

What action have you taken to prevent this occurrence from happening again?

FOR PHYSICIAN USE ONLY:

Attending Physician's Name:	
Comments:	
Signature of Attending Physician:	

If resident died:

Was the coroner notified? ☐ Yes ☐ No	
Date: DD / MM / YYYY	Time: HH:MM ☐ AM ☐ PM

Name of person completing the form:	
Signature:	
Date:	DD / MM / YYYY
Name of Operator/Manager:	
Signature:	
Date:	DD / MM / YYYY

NOTES:

1. Place original form in Resident's File
2. Give a copy to physician
3. If part of the RCF Subsidy Program, notify and provide a copy within 24 hours of occurrence