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