

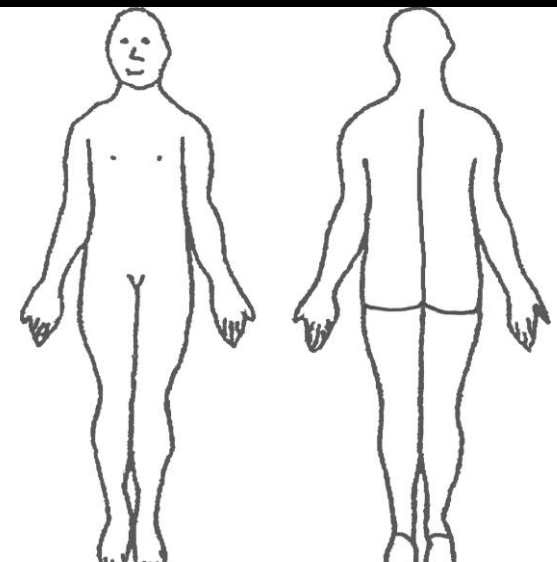
Incident / Accident Report Form

Date	Time	Location
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Victims Name	Date of Birth	Gender
		M / F

Address

Explain how the injury happened and your observations?

Observations	Time	Assessment - indicate area of injury
<p>Level of Consciousness</p> <p style="padding-left: 20px;"><i>Fully Conscious</i></p> <p style="padding-left: 20px;"><i>Drowsy</i></p> <p style="padding-left: 20px;"><i>Unconscious</i></p>	<p>Treatment given</p>	

Is there any recommendations to reduce risk of injury happening again?

Have you de-briefed and reported this within your workplace?

Please ensure privacy is ensured to patient by following these 3 steps
 1. Original to file 2. Copy to Doctor/Ambulance 3. Copy to casualty if requested

Follow Up/Referral	Comments
<input type="checkbox"/> Ambulance	
<input type="checkbox"/> Medical Centre	
<input type="checkbox"/> Parents/Guardian	
<input type="checkbox"/> Other	

First Aider Name (Print):	Signature:
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