BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR
SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☐ PRIVATE PAY ☒ PUBLICLY SUBSIDIZED	☐ FRASER ☒ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (If more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1	s.22		s.22	
2				☐ M ☐ F

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
1			☐ STAFF ☐ OTHER (SPECIFY)
2			☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
21 | 02 | 2014	☐ AM ☒ PM	☐ YES ☒ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☒ Missing person
- ☒ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☐ PRIVATE PAY ☒ PUBLICLY SUBSIDIZED	☐ FRASER ☒ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (If more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1		s.22		
2	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER ☐ M ☐ F
1	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	
2	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
17 | 02 | 2014	2100 ☐ AM ☒ PM	☒ YES ☐ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☒ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

BRITISH COLUMBIA | Ministry Health

ASSISTED LIVING REGISTRAR
SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☑ PRIVATE PAY ☐ PUBLICLY SUBSIDIZED	☐ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1		s.22		
2	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER ☐ M ☐ F
	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	
1				
	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	
2				

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
10/02/2014	5:45 ☐ AM ☑ PM	☑ YES ☐ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☐ Police call
- ☑ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

Pages 4 through 6 redacted for the following reasons:
- -
s.22

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☒ PRIVATE PAY ☐ PUBLICLY SUBSIDIZED	☐ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1		s.22		
2				☐ M ☐ F

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
1			☐ STAFF ☐ OTHER (SPECIFY)
2			☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
18 | 08 | 2013	1:30 ☒ AM ☐ PM	☒ YES ☐ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☐ Police call
- ☒ Other (specify)

  Severe abdominal pain

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

HL

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☒ PRIVATE PAY ☐ PUBLICLY SUBSIDIZED	☐ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1		s.22		
2				☐ M ☐ F

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
1			☐ STAFF ☐ OTHER (SPECIFY)
2			☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
30 | 07 | 2013	☐ AM ☒ PM	☒ YES ☐ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☒ Missing person
- ☐ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

HLTH 1622 2013/03/15

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR
SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☒ PRIVATE PAY ☐ PUBLICLY SUBSIDIZED	☐ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

1	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
		s.22		
2	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER ☐ M ☐ F
1	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	
2	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
11 | 04 | 2013	☒ AM ☐ PM	☐ YES ☐ NO	

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☒ Missing person
- ☐ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

HI

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☐ PRIVATE PAY ☒ PUBLICLY SUBSIDIZED	☒ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

1	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
		s.22		
2	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER ☐ M ☐ F
1	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	
2	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
28 | 03 | 2013	☒ AM ☐ PM	☒ YES ☐ NO	

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☐ Police call
- ☒ Other (specify)

Suicidal thoughts

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SE..OUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☐ PRIVATE PAY ☒ PUBLICLY SUBSIDIZED	☒ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1		s.22		
2	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER ☐ M ☐ F
1	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	
2	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)	

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
01/29/2014	3:15 ☐ AM ☒ PM	☐ YES ☐ NO	

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☒ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

Page 12 redacted for the following reason:
- -
s.22

BRITISH COLUMBIA | Ministry of Health

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf. This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident. Use one form per incident. Tick all applicable boxes.

Fax completed form to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

HEALTH AUTHORITY

☐ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1				
2				

s.22

1
2

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
03/12/2013	7:50 ☒ AM ☐ PM	☐ YES ☒ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☒ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

Page 14 redacted for the following reason:
- -
s.22

BRITISH COLUMBIA | Ministry of Health

SERIOUS INCIDENT REPORT

P: 1 of 1

This form should be completed by the site manager, equivalent or designate. This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf. This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident. Use one form per incident. Tick all applicable boxes.

Fax completed form to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

HEALTH AUTHORITY

☐ FRASER ☑ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1				
2				
1		s.22		
2				

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
06/01/2013	☐ AM ☒ PM	☒ YES ☐ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☒ Police call
- ☑ Other (specify)

s.22

Page 16 redacted for the following reason:
- -
s.22

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf. This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident. Use one form per incident. Tick all applicable boxes.

Fax completed form to the Assisted Living Registrar (250) 952-1119.

p1 of 2

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

HEALTH AUTHORITY

☐ FRASER ☒ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1				
2				
1		s.22		
2				

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
22/09/2013	☒ AM ☐ PM	☐ YES ☒ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☑ Police call
- ☐ Other (specify)

s.22

s.22

Page 18 redacted for the following reason:
- -
s.22

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf. This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident. Use one form per incident. Tick all applicable boxes.

Fax completed form to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

HEALTH AUTHORITY

☑ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1				
2		s.22		
1				
2				

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
15/10/2013	11:30 ☐ AM ☑ PM	☐ YES ☑ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☑ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)

HL

Fax completed form to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

HEALTH AUTHORITY

☑ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1				
2		s.22		

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
1			
2			☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
		s.22	

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. This form is available as a fill-and-print pdf at ww.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf. This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident. Use one form per incident. Tick all applicable boxes.

Fax completed form to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
NAV	s.22	

HEALTH AUTHORITY

☑ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1				
2		s.22		

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
1			☐ STAFF ☐ OTHER (SPECIFY)
2			☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
28 / 06 / 2013	9:45 ☑ AM ☐ PM	☐ YES ☐ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☑ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

HLTH 1622 2012/11/02

Page 22 redacted for the following reason:
- -
s.22

BRITISH COLUMBIA | Ministry Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf. This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident. Use one form per incident. Tick all applicable boxes.

Fax completed form to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

HEALTH AUTHORITY

☑ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1				
2		s.22		

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
1			☐ STAFF ☐ OTHER (SPECIFY)
2			☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
10/06/2013	7:10 ☐ AM ☑ PM	☐ YES ☑ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☑ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

BRITISH COLUMBIA Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf. This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident. Use one form per incident. Tick all applicable boxes.

Fax completed form to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

HEALTH AUTHORITY

☒ FRASER ☐ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1		s.22		
2				☐ M ☐ F

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
1			☐ STAFF ☐ OTHER (SPECIFY)
2			☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
03 | 01 | 2014	☐ AM ☒ PM	☐ YES ☐ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☐ Police call
- ☒ Other (specify) s.22

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

Page 25 redacted for the following reason:
- -
s.22

BRITISH COLUMBIA | Min[illegible] of Hea[illegible]

ASSISTED LIVING REGISTRAI
ERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 852-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☐ PRIVATE PAY ☒ PUBLICLY SUBSIDIZED	☐ FRASER ☒ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (If more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1		s.22		
2	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER ☐ M ☐ F

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
1			☐ STAFF ☐ OTHER (SPECIFY)
2	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
20 | 01 | 2014	15:45 ☐ AM ☒ PM	☒ YES ☐ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☒ Police call
- ☒ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

01/21/2014 08:39 FAX

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
1	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☐ PRIVATE PAY ☑ PUBLICLY SUBSIDIZED	☐ FRASER ☒ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1				
2	s.22			

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
1			☐ STAFF ☐ OTHER (SPECIFY)
2			☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
16 / 04 / 2014	7:30 ☐ AM ☒ PM	☐ YES ☒ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☒ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE | DATE (DD/MM/YYYY)

s.22

BRITISH COLUMBIA | Ministry of Health

ASSISTED LIVING REGISTRAR

SERIOUS INCIDENT REPORT

This form should be completed by the site manager, equivalent or designate. Use one form per incident. Tick all applicable boxes.
This form does not replace the operator's internal investigation form, which would normally be completed by the witness to the serious incident.
This form is available as a fill-and-print pdf at www.health.gov.bc.ca/exforms/assistedliving/1622fil.pdf.
Fax completed form with a cover page to the Assisted Living Registrar (250) 952-1119.

SITE MANAGER AND RESIDENCE CONTACT INFORMATION

NAME OF SITE MANAGER	EMAIL ADDRESS	PHONE NUMBER
	s.22	

INCIDENT INVOLVES RESIDENT(S) IN:	IF PUBLICLY SUBSIDIZED, INDICATE HEALTH AUTHORITY
☐ PRIVATE PAY ☐ PUBLICLY SUBSIDIZED	☐ FRASER ☒ INTERIOR ☐ NORTHERN ☐ VANCOUVER COASTAL ☐ VANCOUVER ISLAND

PARTIES INVOLVED (if more than 2 residents involved or more than 2 witnesses attach separate sheet with the additional names)

	LAST NAME OF RESIDENT INVOLVED	FIRST NAME OF RESIDENT INVOLVED	DATE OF BIRTH (DD/MM/YYYY)	GENDER
1				
2		s.22		

	LAST NAME OF WITNESS	FIRST NAME OF WITNESS	
2			☐ STAFF ☐ OTHER (SPECIFY)

INCIDENT DETAILS

DATE OF INCIDENT (DD/MM/YYYY)	TIME	TRANSFER TO HOSPITAL	WHERE DID INCIDENT TAKE PLACE? (E.G. RESIDENT'S SUITE, COMMON AREA, ETC.)
19 | 04 | 2014	1:30 ☐ AM ☒ PM	☐ YES ☒ NO	s.22

TYPE OF INCIDENT (TICK ALL APPLICABLE BOXES)

- ☐ Attempted suicide by a resident
- ☐ Unexpected death reported to coroner (specify below cause of death if known and contact info for coroner)
- ☐ Abuse or neglect by staff reported to the local abuse and neglect designated agency or office of the public guardian and trustee (specify below, including contact info for person in DA or OPGT to whom incident was reported)
- ☐ Medication error by staff that requires emergency intervention or transfer to hospital (specify below nature of adverse effect and who administered medication)
- ☐ Fire or flood causing personal injury or building damage (specify below cause of fire if known and whether accident or arson)
- ☐ Missing person
- ☒ Police call
- ☐ Other (specify)

EXPLANATION OF INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

IMMEDIATE ACTION TAKEN BY STAFF FOLLOWING INCIDENT (ATTACH SEPARATE SHEET IF NECESSARY)

s.22

SIGNATURE OF SITE MANAGER, EQUIVALENT OR DESIGNATE	DATE (DD/MM/YYYY)
s.22	

Pages 29 through 31 redacted for the following reasons:
- -
s.22