SourcePoint

INCIDENT REPORT FORM

Reporting Agency:	Date & Time of Incident:
Location of Incident:	Name of Client:
Person Reporting:	Care Consultant:
Description of Incident	
What was the result of the incident?	
If Medical services used, contact information for those services	
If Medical Services used, client covered by: ☐ Hospitalization Coverage ☐ Medicare ☐ Automobile	
Name and contacts for any witnesses	
In agency's opinion, cause of the incident	
Recommended Action:	
Will insurance claim be filed with SourcePoint? ☐Yes ☐No ☐Unknown	
Signature of Person Reporting:	Date: