NOVA SCOTIA
Health and Wellness

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**CONFIDENTIAL**

Office Use Only:
Critical Incident File #: _____

# CRITICAL INCIDENT REPORTING FORM

The completed Critical Incident Reporting Form is to be sent to the Department of Health and Wellness within one business day of the incident. The form is to be sent to:

**FAX: 1(902) 722-1239**

| | |
|---|---|
| Date: | |
| Continuing Care Service Provider: | |
| Person submitting report: | |
| Contact number: | |
| Fax number: | |
| Zone: | Zone 1 - Western |
| Date incident occurred: | |
| Time incident occurred: | |
| Location of incident: | |

## Nature of Incident: (please check):

| | |
|---|---|
| ☐ | Unanticipated death/serious health impairment to client/visitor/health care personnel directly associated with care/services |
| ☐ | Unanticipated disruption to health care services for greater than 24 hours |
| ☐ | Events involving multiple clients and/or requiring retroactive notification of event/exposure to risk |
| ☐ | Privacy breach which may impact public trust |
| ☐ | Conditions perceived as public health hazard/disaster management events |
| ☐ | Criminal activity (such as abduction, sexual assault, major theft, embezzlement) |
| ☐ | Events with potential to undermine public confidence in the health care system |
| ☐ | Other – serious event regarding which the service provider believes DHW should be notified |

**It is the responsibility of the service provider to report to any other applicable agencies such as the Medical Examiner, Public Health, Police, Public Trustee etc. as per your established procedures.**

## Description of Incident:

**Did the client(s), visitor(s) or staff member(s) sustain an injury?**

- (•) Yes
- ( ) No
- ( ) Unknown

**If yes, please describe the injury(ies).**

**Is the client's family or substitute-decision maker aware?** ☐ Yes ☐ No

**Has this incident been reported through Protection for Persons in Care?** ☐ Yes ☐ No