*Date AA Rec’d IR:*

**Incident Report**

***REMINDER: All incidents must be reported within 24 hours, and incident report submitted within 48 hours***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Individual Name: | DOB: | | | Region: |
| Date of Incident: | | | Time of incident:       am pm | |
| Location of incident: | | | | |
| Name of agency providing services at the time of incident: | | | | |
|  | |  | | |
| **MEDICAL** | | **LEGAL** | | |
| Hospitalization – medical – admittance not ER visit  Hospitalization – psychiatric – admittance not ER visit  Injury of individual not requiring medical intervention\*  Injury of individual requiring medical intervention\*  Illness of individual not requiring medical intervention\*  Illness of individual requiring medical intervention\*  Seizure  Medication refusal  Fall  Other:  *\*by nursing or medical intervention we mean treatment at a medical facility (e.g. ER, Urgent Care, PCP, etc.)* | | Possible/suspected violation of client rights   *(i.e. potential abuse, neglect, exploitation, or service  rights violation)*  Individual missing/eloped *(even temporarily)*  Police involvement | | |
| **INDIVIDUAL VICTIM OF** | | |
| Theft  Assault  Sexual Assault  Car Accident  Fire hazard/arson | | |
| **SOCIAL** | | | | |
| Behavior incident – no behavior plan  Behavior incident w/behavior plan  Mental Health episode *(suicidal ideation, unusual emotional moods, etc.)*  Physical Restraint utilized  Other: | | | | |

|  |
| --- |
| **What happened prior to the incident:** |
|  |
| **Describe what occurred during this incident (include specific information, i.e. behavior, injury etc.):** |
|  |
| **What action did the reporter or others employ in response to this incident:** |
|  |

|  |  |  |
| --- | --- | --- |
| Signature of Reporter | Date | Time |
| Printed Name of Reporter | Title | |

*Individual Name:*        *Date of Incident:*

**NOTIFICATIONS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Who was notified (Include name, date/time and method of contact):** | | | | | |
| **Name** | **Relationship  to individual** | **Date** | **Time** | **Method of contact** | **By Whom** |
|  | Service Coordinator |  | am pm |  |  |
|  | Program Manager |  | am pm |  |  |
|  | Guardian |  | am pm |  |  |
|  | Additional Service Provider (ex: home) |  | am pm |  |  |
|  | Nursing (if applicable) |  | am pm |  |  |
| Other: |  |  | am pm |  |  |

**REVIEWS**

|  |  |  |
| --- | --- | --- |
| **Program Manager Review/Follow-up** | | |
|  | | |
| Type of Program individual was in during this incident (e.g. CPS, Res, CSS, SEP, 521, etc.):  Has the individual had a service transition within the past 6 months (new home, new home care provider, significant change in service delivery)?  Yes  No If yes, describe the transition and its relationship (if any) to the incident that occurred above: | | |
| If it is a behavioral incident with plan, was the behavior plan followed?        Yes  No  N/A | | |
| Signature of Program Manager | Date | Time |
| Printed Name of Program Manager | Title | |

|  |  |  |
| --- | --- | --- |
| **Service Coordinator/Case Manager Review/Follow-up** | | |
|  | | |
| Is a team meeting required at this time? Yes No | | |
| Signature of Service Coordinator/Case Manager | Date | Time |
| Printed Name of Service Coordinator/Case Manager | Title | |