

Circle of Support, Inc.

INCIDENT REPORT

Consumer's Name: _____ Date: _____
Location: _____ Time: _____ AM / PM

I. CHECK with an (X):

- Alleged Abuse, Alleged Financial Exploitation, Alleged Neglect, Assault, Criminal Conduct, Death, Inappropriate Sexual Behavior, Medical Refusal, Missed Meds/Medication Error, Missing Person, Physical Injury, Physical Aggression towards others, Reportable Injury requiring Medical Attention, Running Away, Seizure, Self-Injurious, Serious Illness/ER Trip/Hospitalization, Alleged Sexual Exploitation, Theft, Vandalism, Verbal Aggression, Verbal Threats, Others

II. DESCRIBE WHAT OCCURRED:

Blank lines for describing the incident.

III. DESCRIBE ACTION TAKEN:

Blank lines for describing actions taken.

IV. WITNESS(ES): Yes ___ No ___ If yes, Witness(es) Names:

Blank line for witness names.

V. MEDICAL ATTENTION REQUIRED: Yes ___ No ___ If yes, where was consumer taken?

Blank line for medical attention details.

Was ambulance required? Yes ___ No ___ Ambulance #: _____
Were police notified? Yes ___ No ___ Police Badge# _____
Was Guardian notified Yes ___ No ___ Date _____ Time _____ AM / PM

VI. QIDP FOLLOW-UP: Yes ___ No ___ If Yes, Action Taken: _____

Blank line for QIDP follow-up details.

Signature/Title of Person Completing Report

Date

Time