**Incident Report**

***REMINDER: All incidents must be reported within 24 hours***

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| Individual Name:       | Region:       | DOB:       |
| 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:       |

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| **Describe what occurred during this incident (include specific information, i.e. behavior, injury etc.):** |
|       |
| **What happened prior to the incident which may have contributed to its occurrence or to the likelihood of its occurrence:** |
|       |
| **What action did the reporter or others employ in response to this incident:** |
|       |

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| **Who was notified (Include name, date/time and method of contact):**  |
| **Name** | **Relationship  to individual** | **Date** | **Time** | **Method of contact** |
|       | Service Coordinator |       |       [ ] am [ ] pm |       |
|       | Program Supervisor |       |       [ ] am [ ] pm |       |
|       | Guardian |       |       [ ] am [ ] pm |       |
|       | Additional Service Provider (ex: home) |       |       [ ] am [ ] pm |       |
|       | Nursing (if applicable) |       |       [ ] am [ ] pm |       |
| Other:       |       |       |       [ ] am [ ] pm |       |
| Printed Name:      | Title      |
| Signature of Reporter | Date      | Time      |

**REVIEWS**

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| **Program Manager Review/Follow-up**  |
|       |
| 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:      |
| Did incident result in nursing or medical intervention? [ ] Yes [ ] No If, yes, please attach Nursing/Medical Intervention Report. |
| If it is a behavioral incident with plan, was the behavior plan followed?       [ ]  Yes [ ]  No |
| Signature of Program Manager | Date      | Time      |
| Printed Name of Program Manager      | Title       |

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| **Service Coordinator/Case Manager Review/Follow-up** |
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| 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       |