

INCIDENT REPORT FORM

Incident # _____

Date: _____

Individual Name _____ DOB: _____

Address: _____

Phone: _____

PPI Name & Relationship to Individual: _____

INCIDENT LOCATION - BUILDING

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Time of Incident: Began: _____ AM PM Ended: _____ AM PM

Place of Incident: _____

Type of Incident:	<input type="checkbox"/> Neglect	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Missing Individual	<input type="checkbox"/> Medication/Medical error
<input type="checkbox"/> Accidental/Suspicious Death	<input type="checkbox"/> Peer to Peer	<input type="checkbox"/> Verbal Abuse	<input type="checkbox"/> Significant Injury	<input type="checkbox"/> Fall
<input type="checkbox"/> Exploitation	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Bruises
<input type="checkbox"/> Failure to Report	<input type="checkbox"/> Prohibited Sexual Relations	<input type="checkbox"/> Death other than accidental or suspicious	<input type="checkbox"/> Unapproved Behavior Support (Describe details below)	<input type="checkbox"/> Property Destruction
<input type="checkbox"/> Missappropriation	<input type="checkbox"/> Rights Code Violation	<input type="checkbox"/> Medical Emergency	<input type="checkbox"/> Unscheduled Hospitalization	

Incident Description: Include what was taking place just prior to the incident. Note any unsafe conditions that contributed to the incident. If the incident is of unknown origin, be specific as to how it was discovered and what the individual was doing.

IMMEDIATE ACTION TAKEN (WHAT STEPS WERE TAKEN TO ENSURE HEALTH AND WELFARE?)

CAUSE AND CONTRIBUTING FACTORS	<input type="checkbox"/> NA	<input type="checkbox"/> YES	If Yes, identify _____

PREVENTION PLAN

Was Help Hotline called?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Time: _____	<input type="checkbox"/> AM	<input type="checkbox"/> PM	By whom: _____	Date: _____
Was parent/guardian/advocate notified?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Time: _____	<input type="checkbox"/> AM	<input type="checkbox"/> PM	By whom: _____	Date: _____
Was SSA notified: (MUI's only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Time: _____	<input type="checkbox"/> AM	<input type="checkbox"/> PM	By whom: _____	Date: _____
Was ICF/MR called?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Time: _____	<input type="checkbox"/> AM	<input type="checkbox"/> PM	By whom: _____	Date: _____
Licensed/Certified Provider	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Time: _____	<input type="checkbox"/> AM	<input type="checkbox"/> PM	By whom: _____	Date: _____
Staff or family living at Individuals home & responsible for care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Time: _____	<input type="checkbox"/> AM	<input type="checkbox"/> PM	By whom: _____	Date: _____
Law Enforcement/Badge Number	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Time: _____	<input type="checkbox"/> AM	<input type="checkbox"/> PM	By whom: _____	Date: _____

Staff Witnessing Incident	Location During Incident	Staff Activity at Time of Incident	Date

Signature of person completing this report: _____ **Date:** _____

Building Administrator: _____ **Date:** _____

Habilitation Coordinator: _____ **Date:** _____

Copy of this form must be faxed to Investigative Agent within 24 hours or by 3 pm following day of incident. (MUIs only)

Faxed by whom: _____

HEALTH OFFICE REFERRAL

Name: _____ Present Location: _____
 Date: _____ Time: _____

Reason for Referral: _____

(Nurse's Signature)

(Referred by - Signature)

Nurse's Health Office Referral Notes:

- Copy of this form must be faxed to Investigative Agent within 24 hours or by 3 pm following day of incident. (MUIs only)
- Copy of Nurse's form must be faxed to ICF

Faxed by whom: _____

Use red ink to mark on figures any bruises, cuts, marks, etc.

