Incident Report

REMINDER: All incidents must be reported within 24 hours

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

- ☐ 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.)*

LEGAL

- ☐ 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:

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:

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

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	

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	