*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**

|  |
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| **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       |