

REPORTING AGENCY: Support, Incorporated

**INCIDENT REPORT**

<b>NAME OF PERSON:</b>		
<b>OCCURRENCE DATE:</b>	<b>TIME:</b>	
<b>DURATION OF INCIDENT:</b>	<b>LOCATION:</b>	
<b>IF CONTROL PROCEDURE, DURATION OF PHYSICAL INTERVENTION:</b>		
<b>WAS INCIDENT OBSERVED DIRECTLY?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>TYPE OF INCIDENT</b>		
<b>MEDICAL/INJURY</b>	<b>SOCIAL/BEHAVIORAL</b>	
<input type="checkbox"/> Injury to Consumer	<input type="checkbox"/> Lost or Missing Person	
<input type="checkbox"/> Medical Emergency	<input type="checkbox"/> Aggression toward Others	
<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Self-Injurious Behavior	
<input type="checkbox"/> Death of Consumer	<input type="checkbox"/> Property Damage	
<input type="checkbox"/> Seizure of Unusual Nature	<input type="checkbox"/> Theft or Vandalism	
<input type="checkbox"/> Medication/Charting Error	<input type="checkbox"/> Unusual Behavior	
<input type="checkbox"/> Alleged Mistreatment, Abuse, Neglect, Exploitation	<input type="checkbox"/> Emergency Control Procedure (see pg. 2)	
	<input type="checkbox"/> Safety Control Procedure (see pg. 2)	
	<input type="checkbox"/> Stolen Property of Persons Receiving Services	
<b>OTHER:</b>		
<b>WITNESSED BY:</b>	<b>OR REPORTED BY:</b>	
<b>NOTE POINT OF INJURY OR PAIN:</b>		
<b>PERSONS NOTIFIED:</b>	<b>DATE:</b>	<b>ROUTED:</b>
<input type="checkbox"/> Nurse _____	_____	<input type="checkbox"/>
<input type="checkbox"/> Case Manager _____	_____	<input type="checkbox"/>
<input type="checkbox"/> Guardian/Parent/Provider _____	_____	<input type="checkbox"/>
<input type="checkbox"/> Dept. of Health (Group Homes only) _____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other _____	_____	<input type="checkbox"/>
<input type="checkbox"/> _____	_____	<input type="checkbox"/>
<input type="checkbox"/> _____	_____	<input type="checkbox"/>
<input type="checkbox"/> Division of Developmental Disabilities-DDD Critical Incident	_____	<input type="checkbox"/>
<b>Description of Incident: (FACTUAL INFORMATION ONLY)</b>		
<b>Describe the events and environment leading up to the incident:</b>		
<b>How was the situation handled?</b>		

over

<b>Was an Emergency/Safety Control Procedure used?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Starting time of procedure:</b>	<b>Ending time:</b>
<b>Describe the procedure used:</b>	
<b>Why was the procedure used?</b>	
<b>Has this type of behavior occurred with this person before?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Is it likely that this behavior will recur?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Is there a behavioral ISSP?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Was it implemented?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Comment:</b>	
<b>Measures to be taken or suggestions for preventing a reoccurrence of this incident:</b>	

<b>Report Written By</b> (print/type name):
<b>SIGNATURE OF PERSON COMPLETING REPORT:</b> _____
<b>DATE REPORT WRITTEN:</b>

=====

**TO BE COMPLETED BY SUPERVISOR:**

<b>Follow-up action requested:</b>
<input type="checkbox"/> No follow-up necessary
<input type="checkbox"/> IDT meeting/review necessary <input type="checkbox"/> Additional training needed <input type="checkbox"/> Other:
<b>Comments:</b> _____
_____
_____
_____

<b>Person responsible for follow-up:</b>
<b>Follow-up action completed:</b>
<b>If follow-up is not completed in this section, indicate where documentation of follow-up can be located:</b>
<b>Date Completed:</b>
<b>Completed By:</b>

<b>Signatures:</b>	<b>Date</b>
<b>Nurse:</b> _____	_____
<b>Case Manager:</b> _____	_____
<b>Supervisor:</b> _____	_____