

# UNUSUAL INCIDENT/INJURY REPORT

**INSTRUCTIONS :** NOTIFY LICENSING AGENCY, PLACEMENT AGENCY AND RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY.

SUBMIT WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE.

RETAIN COPY OF REPORT IN CLIENT'S FILE.

NAME OF FACILITY		FACILITY FILE NUMBER	TELEPHONE NUMBER (     )
ADDRESS		CITY, STATE, ZIP	

CLIENTS/RESIDENTS INVOLVED	DATE OCCURRED	AGE	SEX	DATE OF ADMISSION

**TYPE OF INCIDENT**

- |  |   |  |   |   |
|--|---|--|---|---|
| <input type="checkbox"/> Unauthorized Absence            | <input type="checkbox"/> Alleged Client Abuse | <input type="checkbox"/> Rape            | <input type="checkbox"/> Injury-Accident              | <input type="checkbox"/> Medical Emergency        |
| <input type="checkbox"/> Aggressive Act/Self             | <input type="checkbox"/> Sexual               | <input type="checkbox"/> Pregnancy       | <input type="checkbox"/> Injury-Unknown Origin        | <input type="checkbox"/> Other Sexual Incident    |
| <input type="checkbox"/> Aggressive Act/Another Client   | <input type="checkbox"/> Physical             | <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Injury-From another Client   | <input type="checkbox"/> Theft                    |
| <input type="checkbox"/> Aggressive Act/Staff            | <input type="checkbox"/> Psychological        | <input type="checkbox"/> Other           | <input type="checkbox"/> Injury-From behavior episode | <input type="checkbox"/> Fire                     |
| <input type="checkbox"/> Aggressive Act/Family, Visitors | <input type="checkbox"/> Financial            |  | <input type="checkbox"/> Epidemic Outbreak            | <input type="checkbox"/> Property Damage          |
| <input type="checkbox"/> Alleged Violation of Rights     | <input type="checkbox"/> Neglect              |  | <input type="checkbox"/> Hospitalization              | <input type="checkbox"/> Other ( <i>explain</i> ) |

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTECEDENTS LEADING UP TO INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY INJURIES:

---



---



---



---



---

PERSON(S) WHO OBSERVED THE INCIDENT/INJURY:

---



---



---



---

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CONTACTED):

---



---



---



---

MEDICAL TREATMENT NECESSARY?  YES  NO IF YES, GIVE NATURE OF TREATMENT:

WHERE ADMINISTERED:

ADMINISTERED BY:

FOLLOW-UP TREATMENT, IF ANY:

ACTION TAKEN OR PLANNED (BY WHOM AND ANTICIPATED RESULTS:

LICENSEE/SUPERVISOR COMMENTS:

NAME OF ATTENDING PHYSICIAN

REPORT SUBMITTED BY:	NAME AND TITLE	DATE
REPORT REVIEWED/APPROVED BY:	NAME AND TITLE	DATE

**AGENCIES/INDIVIDUALS NOTIFIED** (SPECIFY NAME AND TELEPHONE NUMBER)

- LICENSING \_\_\_\_\_  ADULT/CHILD PROTECTIVE SERVICES \_\_\_\_\_
- LONG TERM CARE OMBUDSMAN \_\_\_\_\_  PARENT/GUARDIAN/CONSERVATOR \_\_\_\_\_
- LAW ENFORCEMENT \_\_\_\_\_  PLACEMENT AGENCY \_\_\_\_\_