

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 _____