



Incident Report

IDENTIFYING INFORMATION:

Client Name:		DOB:	Client ID#
Client Address:			
Reporting Service Site/Name:			AFC License #:
Incident Date:	Incident Time:	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Unknown	Discovered Date:
Incident Location (bedroom, kitchen, sidewalk, etc.):			
Place/Address of Incident (if different from client's address):			
Other person(s) involved/witnesses:			

DESCRIPTION OF THE INCIDENT:

Describe events leading up to the incident, what happened, and any injury to clients or others (attach pages if needed):		
Describe the actions taken by staff, any medical treatment given, and outcome to client:		
Name of treating doctor/clinic/hospital:	Phone #:	Date/time care given:
Diagnosis given by medical professional:		

IR AUTHOR SIGNATURE:

Author:	Print author name/title:	Date:



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TYPE OF INCIDENT (check box(es) to left of category):

<input type="checkbox"/>	Accident-Fall	<input type="checkbox"/>	EMT* for harm to self or others	<input type="checkbox"/>	Medication missed, refused
<input type="checkbox"/>	Accident- Vehicle	<input type="checkbox"/>	EMT* for injury or med. error	<input type="checkbox"/>	Medication count discrepancy
<input type="checkbox"/>	Aggressive behavior (aggressor)	<input type="checkbox"/>	EMT* for illness	<input type="checkbox"/>	Other
<input type="checkbox"/>	Aggressive behavior w/ physical management *** (see below)	<input type="checkbox"/>	Hospital admission** for harm to self or others	<input type="checkbox"/>	Suicide
<input type="checkbox"/>	Arrest of client	<input type="checkbox"/>	Hospital admission** for illness	<input type="checkbox"/>	Unusual and adverse event
<input type="checkbox"/>	Death	<input type="checkbox"/>	Hospital admission** injury or med error	<input type="checkbox"/>	911 Call for behavioral crisis*** (see below)
<input type="checkbox"/>	Elopement	<input type="checkbox"/>	Medication error (5-rights)	<input type="checkbox"/>	

* Emergency Medical Treatment (EMT) means the client is seen face to face by a medical professional, Emergency Room/Department, 911/Ambulance, walk-in clinic/ urgent care, same day PCP appointment, etc.

**An ER visit is not a hospital admission unless or until the client is officially admitted to an inpatient room.

***Attach "**Justification for Physical Management/Law Enforcement**" form for EACH use of physical management and/or staff call to law enforcement for behavioral crisis.

PHYSICAL MANAGEMENT:

Start Time:	End Time:	Client injured during physical management? <input type="checkbox"/> Yes <input type="checkbox"/> No
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SUPERVISOR IR REVIEW:

Employee assigned to the individual at time of incident (if applicable):
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Corrective measures taken to remedy and/or prevent recurrence:
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Supervisor Signature:	Print name/title:	Date:
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OTHERS NOTIFIED (record initials of reporter in box(es) to the left):

<input type="checkbox"/>	NCCMH primary case holder/RN <i>(if immediate notification is required)</i>	<input type="checkbox"/>	APS/CPS <i>(if neglect/abuse suspected)</i>	<input type="checkbox"/>	LARA AFC Licensing
<input type="checkbox"/>	Law Enforcement <i>(if employee criminal activity suspected)</i>	<input type="checkbox"/>	Parent/Legal Guardian	<input type="checkbox"/>	ORR <i>(if RR allegation suspected)</i>