

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

☐ Unauthorized Absence	☐ Alleged Client Abuse	☐ Rape	☐ Injury-Accident	☐ Medical Emergency
☐ Aggressive Act/Self	☐ Sexual	☐ Pregnancy	☐ Injury-Unknown Origin	☐ Other Sexual Incident
☐ Aggressive Act/Another Client	☐ Physical	☐ Suicide Attempt	☐ Injury-From another Client	☐ Theft
☐ Aggressive Act/Staff	☐ Psychological	☐ Other	☐ Injury-From behavior episode	☐ Fire
☐ Aggressive Act/Family, Visitors	☐ Financial		☐ Epidemic Outbreak	☐ Property Damage
☐ Alleged Violation of Rights	☐ Neglect		☐ Hospitalization	☐ 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:

FOLLOW-UP TREATMENT, IF ANY:

ACTION TAKEN OR PLANNED (BY WHOM AND ANTICIPATED RESULTS:

LICENSEE/SUPERVISOR COMMENTS:

NAME OF ATTENDING PHYSICIAN

DATE

DATE

AGENCIES/INDIVIDUALS NOTIFIED (SPECIFY NAME AND TELEPHONE NUMBER)

☐ LAW ENFORCEMENT ☐ PLACEMENT AGENCY