

# UNUSUAL OCCURRENCE/INCIDENT REPORT

*(Not part of Medical Record)*

<b>CLIENT INFORMATION</b>		Last Name _____	First Name _____
Chart No. _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Age _____ Birthdate: _____
Reporting Clinic/Contract Agency _____		Date last seen by Staff _____	
Name of Clinic/Contractor _____		Family Notified: <input type="checkbox"/> Telephone <input type="checkbox"/> Letter <input type="checkbox"/> None	
Name of Program Delivering Services _____		Family Contact Name _____	
Client Address/Phone _____			
<b>INCIDENT</b> (Please check all that apply)		<input type="checkbox"/> Disturbance/Destruction of Property**	<input type="checkbox"/> Dangerous Behavior -- Self
<input type="checkbox"/> Dangerous Behavior – Others	<input type="checkbox"/> Victimized	<input type="checkbox"/> Sexual Behavior	
<input type="checkbox"/> Medical/Injury**	<input type="checkbox"/> Death* Date Deceased _____	<input type="checkbox"/> Other _____	
<b>LOCATION OF INCIDENT</b>		<input type="checkbox"/> Within Clinic	<input type="checkbox"/> Surrounding Clinic (grounds, parking lot,)
<input type="checkbox"/> Residential	<input type="checkbox"/> Client Residence, Independent Living	<input type="checkbox"/> Other (Please specify)	
<b>EXPLANATION OF INCIDENT*</b> <small>include names of witnesses</small>		<b>DATE OF INCIDENT:</b>	
		<b>TIME:</b>	
WITNESSES:			
<b>ACTION TAKEN</b> (Please check all that apply)		<input type="checkbox"/> Counseling, reassuring, removal of client	<input type="checkbox"/> First Aid
<input type="checkbox"/> Consulting with Physician (Phone or office visit)	<input type="checkbox"/> Called Paramedics	<input type="checkbox"/> Staff escort out of building	
<input type="checkbox"/> Police called	<input type="checkbox"/> Other Report (CFS, APS, Licensing)		
<input type="checkbox"/> Other (Please Specify)			
<b>EXPLANATION OF ACTION TAKEN*</b>			
<b>SUPERVISORS COMMENTS*</b> <small>Include, e.g.: Family Responses, Date of Last Service, Last ID Note comments (SI, HI, Grave Disability, etc.), Client compliance issues (transportation, child care, etc.) as appropriate</small>			
Signature of Supervisor _____			
<b>NOTIFICATION</b> (check all that apply, include date and method of notification ie. phone, fax, email in the space provided)			
<input type="checkbox"/> Director _____	<input type="checkbox"/> Program Manager _____		
<input type="checkbox"/> Assistant Director _____	<input type="checkbox"/> Department Safety Coordinator _____		
<input type="checkbox"/> Deputy Director _____	<input type="checkbox"/> Medical Director _____		
<input type="checkbox"/> Chief Compliance Officer _____			
<b>AUTHOR INFORMATION</b> (Who completed form)		Date _____	Title _____
Printed Name _____			
Signature _____			

\*Add additional sheet as needed

**Follow-up outcome should be reported to the Office of Compliance**

\*\*Office of compliance shall determine if report required to Department of Risk Management