UNUSUAL OCCURRENCE/INCIDENT REPORT

(Not part of Medical Record)

CLIENT INFORMATION

Last Name ____________ First Name ____________

Chart No. ____________ Gender: ☐ Male ☐ Female ☒ Unknown Age ______ Birthdate: ____________

Reporting Clinic/Contract Agency ____________ Date last seen by Staff ____________

Name of Clinic/Contractor ____________ Family Notified: ☐ Telephone ☐ Letter ☐ None

Name of Program Delivering Services ____________ Family Contact Name ____________

Client Address/Phone ____________

INCIDENT (Please check all that apply)

☐ Disturbance/Destruction of Property** ☐ Dangerous Behavior -- Self
☐ Dangerous Behavior – Others ☐ Victimized ☐ Sexual Behavior
☐ Medical/Injury** ☐ Death* Date Deceased ______ ☐ Other ______

LOCATION OF INCIDENT

☐ Within Clinic ☐ Surrounding Clinic (grounds, parking lot,)
☐ Residential ☐ Client Residence, Independent Living ☐ Other (Please specify)

EXPLANATION OF INCIDENT* include names of witnesses

DATE OF INCIDENT: TIME:

WITNESSES:

ACTION TAKEN (Please check all that apply)

☐ Counseling, reassuring, removal of client ☐ First Aid
☐ Consulting with Physician (Phone or office visit) ☐ Called Paramedics ☐ Staff escort out of building
☐ Police called ☐ Other Report (CFS, APS, Licensing)
☐ Other (Please Specify)

EXPLANATION OF ACTION TAKEN*

SUPERVISORS COMMENTS* 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

Signature of Supervisor

NOTIFICATION (check all that apply, include date and method of notification ie. phone, fax, email in the space provided)

☐ Director ____________ ☐ Program Manager ____________
☐ Assistant Director ____________ ☐ Department Safety Coordinator ____________
☐ Deputy Director ____________ ☐ Medical Director ____________
☐ Chief Compliance Officer ____________ ☐ Program Coordinator ____________

AUTHOR INFORMATION (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