

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

☐ Aggressive Act/Self

☐ Aggressive Act/Another Client

☐ Aggressive Act/Staff

☐ Aggressive Act/Family, Visitors

☐ Alleged Violation of Rights

Alleged Client Abuse

☐ Sexual

☐ Physical

☐ Psychological

☐ Financial

☐ Neglect

☐ Rape

☐ Pregnancy

☐ Suicide Attempt

☐ Other

☐ Injury-Accident

☐ Injury-Unknown Origin

☐ Injury-From another Client

☐ Injury-From behavior episode

☐ Epidemic Outbreak

☐ Hospitalization

☐ Medical Emergency

☐ Other Sexual Incident

☐ Theft

☐ Fire

☐ Property Damage

☐ Other (explain)

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