Real Care, Inc. Incident Report

Name of Individual Receiving Services: test Initialed By: test

Date Incident Occurred: _____ Time: _____ am / pm How Long Did Incident Last: _____

Where Did the Incident Occur: _____ *(Home, Community, Day Program, etc.)*

Other People Involved (names): _____

Witness(s): _____

Did you see the incident occur? ☐ Yes ☐ No

Check the Type of Incident

- ☐ Injury to Client in service setting
- ☐ Lost or Missing Person
- ☐ Injury to Client-unknown
- ☐ Aggression towards Others
- ☐ Medical Emergency
- ☐ Self-Injurious Behavior
- ☐ Hospitalization
- ☐ Property Damage
- ☐ Medication/Charting Error
- ☐ Death of Consumer
- ☐ Other: _____
- ☐ Theft or Vandalism
- ☐ Seizure
- ☐ Unusual Behavior
- ☐ Alleged Mistreatment, Abuse, Neglect, Exploitation
- ☐ Emergency Control Procedure
- ☐ Safety Control Procedure
- ☐ Stolen Property of Client
- ☐ Worker's Compensation

Describe Point of Injury and / or pain: _____

_____

First Aid Given ☐ Yes ☐ No Who Provided First Aid: _____

Description of Injury / pain: _____

Persons Notified:		Date:	Routed:
☐ Guardian	_____	_____	☐
☐ HHP / FCG	_____	_____	☐
☐ PASA Rep	_____	_____	☐
☐ Nurse	_____	_____	☐
☐ Other	_____	_____	☐

Describe the Incident – Include only factual information rather than opinions

_____

_____

_____

_____

_____

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Describe the events and environment leading up to the incident. _____

_____

How was the situation handled? _____

_____

Measures to be taken or suggestions for preventing a re-occurrence of this incident: _____

_____

For Behavioral Incidents Only

Was an Emergency Control / Safety Procedure Used? ☐ Yes ☐ No (if no, please skip the questions below)

Starting time of Procedure: _____ Ending Time: _____

Describe the Procedure Used: _____ Why was the Procedure Used? _____

Has this type of behavior occurred before? ☐ Yes ☐ No Is it likely that this behavior will reoccur? ☐ Yes ☐ No

Is there a Behavioral ISSP? ☐ Yes ☐ No Was it implemented? ☐ Yes ☐ No

Comment: _____

_____

_____ _____

Report Written By: **Date Written**

For Administration Only

Follow-up Action:_____

_____

Person Responsible for Follow-Up: _____

Follow-up Action Completed**:** _____

_____

_____

Signatures

_____ _____

Real Care Inc. Representative Date

_____ _____

Real Care, Inc. Client Relations Manager or Director Date

_____ _____

Real Care, Inc. Nurse (if applicable) Date

_____ _____

Case Management Representative Date

SUBMIT