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Center for Social Change, Inc.

Incident Report Form

Individual's Initials: _____ Residential Address: _____
Is more than one individual involved? Yes ☐ No ☐ [Please circle]
If yes, a separate report is required for each individual.
Individual is in the following program/s: Residential ( ) SE ( )
Location of Incident: _____ Date: _____ Time: _____ AM / PM
List names of staffs present: 1. _____ 2. _____
3. _____
If any staff is a witness to the incident, a separate incident report must be submitted by that staff person

Type of Incident: (Check all that are appropriate)

☐ Injury ☐ Hospitalization ☐ Missing Individual ☐ Police/Fire Involvement
☐ Illness ☐ Neglect ☐ Property Damage ☐ Abuse ☐ Other
☐ Behavior (formal Program: y or N) ☐ Theft ☐ Medication Error ☐ Death

ALL INCIDENTS SHOULD BE REPORTED AND AN INCIDENT REPORT FORM COMPLETED
(Use first and last initials only for all individual's involved. Objective description of incident is absolutely necessary.
Explain the circumstances that have led to the incident. [Be Specific]

Explain exactly what happened during the incident. [Be Objective]

How long did the incident last? What happened after the incident?

This incident report has been prepared by:

_____ _____ _____
PRINT NAME (CAPITAL LETTERS) SIGN DATE

Incident has been reported to:

Title	Name	Date	Time
Supervisor			
On Call Emergency Supervisor			
Delegating Nurse (For medical only)			

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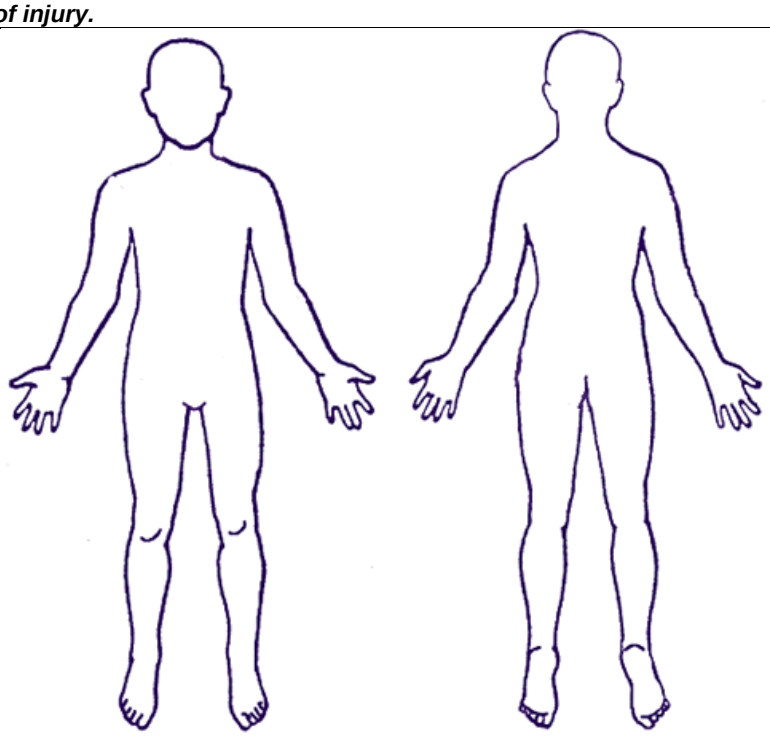
***If there is an injury to the individual, complete the following*:**

Was the person physically injured? YES NO

Place an X to designate the area of injury.

Type of Injury:
- Scratch
- Swelling
- Bruise
- Bite
- Other

Body Parts Injured
- Head/Face
- Neck/Chest
- Feet/Legs
- Mouth/Teeth
- Abdomen
- Genitals
- Hands/Arms
- Back/Buttocks



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Was the delegating nurse notified? (DO NOT REPORT NON-MEDICAL INCIDENTS TO RN)

YES ◯ Yes or No (please circle) If yes, complete the following:

Name of RN: _____ Time of Report:_____

NO ◯ What follow up action was recommended by the RN: _____

Was the individual taken to the hospital?

YES If yes, when? _____ Where? _____

NO

Transported by paramedics?

Transported by company van?

Was medical treatment indicated at the ER/Hospital?

YES If yes, Discharged? Yes or No Admitted? Yes or No ***(please circle)***

NO Do you have paperwork? Yes or No ***(please circle)***

Employee Name		**Date**	
Employee Signature		**Time**	

Witnesses to the incident:

NAME	SIGNATURE	Date	Time

Individuals are not considered witnesses. If any staff is a witness to the incident, a separate incident report-not an employee statement** must be submitted by that staff person.*

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If law enforcement is involved, please complete the following:

Were the Police Notified? Yes or No ***(please circle)***

If YES, please complete the next section.

If NO, please go to next page.

Time of Police Call:	
Time Police Arrived:	
Police Officer's Name:	
Police Officer's Badge Number:	
Police Officer's Jurisdiction: (i.e. Howard County)	
Police Officer's Precinct: (i.e. Woodlawn)	
Report Number:	

Comments Made by Police Officer that are relevant to the incident:

Please note all pages of the Incident report are to be completed if an injury is involved, individual goes to the ER or is hospitalized and if police were involved at the same time.

Employee Name:	
Employee Signature:	
Date Completed:	

Office Use Only:

Date of Incident:	**Date Family/Guardian Notified:**
Date Submitted to Office:	**Name of Service Coordinator:**
Date Entered into Data Base:	**Date Service Coordinator Notified:**

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Additional Information: (This page may also be used by the supervisor to document their statement.) (Use one page per employee).

Please note all pages of the Incident report are to be completed if an injury is involved, individual goes to the ER or is hospitalized and if police were involved at the same time.

Employee Name		**Date**	
Employee Signature		**Time**	

Signature of Witness:

NAME	SIGNATURE	DATE	TIME

Office Use only

Incident Review By:

NAME	SIGNATURE	Date	Time
Coordinator			
IP Specialist			
BP Specialist			
Director of Clinical Services			
Director of Community Housing			
Director of Employment Services/Incidents			
Director of Operations			
Director of Quality Assurance			

**Individual's may not be considered witnesses. Staff witnesses must submit separate report.*