SERIOUS INCIDENT/INJURY OR DEATH IN A LICENSED PROGRAM

Program where Individual received services: _____

Consumer Name: (First, MI, Last)_____ Date of Birth _____/_____/_____

Consumer Address: _____ Consumer Tel. #: _____

Ethnicity/Race: _____ Gender: _____ Medicaid#:_____

Date of death/incident _____/_____/_____ Time of Incident: _____ am _____ pm

Date of Discovery of death/incident _____/_____/_____ Time of Discovery: _____ am _____ pm

Waiver Service Recipient? ☐ Yes ☐ No

Waiver Type: ☐ Building Independence ☐ Family & Individual Support ☐ Community Living
☐ EDCD ☐ MH Adolescent ☐ Other

Complete for serious INJURIES only (check all that apply)

☐ Adverse Reaction
☐ Abrasion/Cut/Scratch
☐ Burn
☐ Bite
☐ Contusion/Hematoma
☐ Dislocation/ Fracture
☐ Laceration
☐ Redness/Swelling
☐ Sprain
☐ Other_____

Complete for serious INCIDENTS only (check all that apply)

☐ Assault by client
☐ Assault by staff
☐ Choking
☐ Elopement/Runaway
☐ Heart Attack
☐ Homicidal Ideation
☐ Ingestion of Substance
☐ Medication Error
☐ MRSA/Infection
☐ Overnight absence without permission
☐ Possession of weapon
☐ Seizure/Convulsion
☐ Sexual Misconduct
☐ Overdose
☐ Stroke
☐ Suicidal Ideation
☐ Suicidal Attempt
☐ Other_____

COMPLETE FOR SERIOUS INJURIES and INCIDENTS

Did this injury or incident involve loss of consciousness? ☐ Yes ☐ No

Medical Attention Provided? ☐ Yes ☐ No Date:_____/_____/_____ Time _____ am _____ pm

Medical Attention Type: ☐ Emergency ☐ Non-Emergency

Description of Medical Treatment Provided & Finding: _____

Complete for DEATHS only (check all that apply)

☐ Accidental ☐ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

COMPLETE FOR DEATHS ONLY

Was the death ☐ Expected? ☐ Unexpected?

Referred to Medical Examiner? ☐ Yes ☐ No

Is autopsy to be performed? ☐ Yes ☐ No If yes, status _____

Cause (from death certificate) _____

State other known facts regarding incident or death (attach additional notes, if necessary):

Did the incident involve? (Check all that apply)

☐ Abuse Allegation? ☐ Neglect Allegation? ☐ Seclusion? ☐ Restraint?
☐ Self-injurious Behavior? ☐ Unexplained? ☐ Other? _____

Notifications: (This section must be completed)

Does this Individual have a Guardian/AR? ☐ Yes ☐ No

If yes, enter Guardian/Authorized Representative's (AR) Name:

Relationship: ☐ Guardian ☐ Parent ☐ A/R ☐ Other:

Other Entities/Persons notified:

☐ DBHDS ☐ APS ☐ CPS ☐ Police ☐ Program Supervisor Manager ☐ Program Director

Other:

Current location and status of the Individual:

Steps taken to ensure the Individual's continued safety:

Service Staff Name/Title:_____ Date of Completion: _____