Incident Reporting Form

Date of Report:	**Date of Incident:**	**Time of Incident:** □ **am** □ **pm**
Provider Name:		
Program Name:	**Service:**	
Reported By:		

Event Codes (Check All That Apply)

□ **SU** Suicide (Attempt or Completed)	□ **EMG** Emergency Room Treatment	□ **SR** Seclusion/Restraint
□ **ACL** Absence from Community Living	□ **ABN** Abuse/Neglect	□ **WKV** Workplace Violence
□ **ELP** Elopement	□ **DIS** Disaster	□ **MED** Medication Error
□ **INJ** Injury	□ **EVC** Evacuation	□ **OTH** Other (describe below in narrative)

Description of Incident:

Person(s) Involved In Incident:	Is this person on the ID/DD Waiver? □ **Yes** □ **No**
Witnesses:	
Possible Contributing Factors:	
Consequences/Follow Up Actions:	
Any and all authoritative bodies to which this incident has been reported and the dates of those reports.	
Has a Report of Incident been made within the agency? □ **Yes** □ **No**	
If yes, to whom has the Report of Incident been made? _____ Name _____ Position _____ Name _____ Position _____ Name _____ Position	
At the time of this report, is the Agency conducting an Internal Investigation? □ **Yes** □ **No**	
If yes, is the Agency's Investigation Active or Closed?	
Is this a high visibility Incident? □ **Yes** □ **No**	