Route To	Sign	Date

INCIDENT REPORT

Person Served Name:_____

Date of Incident: _____/_____/_____ Time:_____AM / PM Location:_____

Program(s) in which person served is enrolled *(if enrolled in both Residential & Day Program, fill in both):*

Day Program
Address:_____
_____

Residential
Address:_____
_____

Other Residential
Provider(specify):_____
Address:_____
Home Address:_____

Type of Incident *(check all appropriate):*

- ☐ Injury
- ☐ Illness
- ☐ Medication error
- ☐ Hospitalization
- ☐ Alleged neglect
- ☐ Alleged abuse
- ☐ Missing Person Served
- ☐ Damage/Destruction of Property
- ☐ Theft
- ☐ Police/Fire Involvement
- ☐ Behavior (formal program? ☐ Yes ☐ No)
- ☐ Death
- ☐ Other_____

Individual(s) other than Person Served involved in incident:

Name	Position or Relation to Person Served

Notification made to:

Name/Relationship	By: (Name/Position)	VIA: (Visit/Phone/Letter – Note Date)

Brief, factual description of incident, including immediate response *(continue on second page if necessary):*

_____

_____

_____

_____

_____

_____

_____

_____

Completed By:_____ Position:_____ Date:_____

Follow-up, if any:		
Completed By:	Position:	Date:

Copies to: Quality Assurance_____; Program Director, and the File

Code:_____ Date:_____ Input By:_____

Person Served Name:_____

Date of Incident: _____/_____/_____ **Time Incident Occurred**: _____ AM / PM