# State of Maryland, Department of Health and Mental Hygiene
# Developmental Disabilities Administration
# Incident Reporting Form

**APPENDIX 4**

**A) Was more than one individual involved in this incident? ☐Y ☐N. If Yes, submit a separate Appendix 4 for each individual. In order to link all individuals in one incident, please provide the name and Social Security number for each additional individual involved in the space provided below. (If more than 3 please attach additional page)**

| 1) | 2) | 3) |
|---|---|---|

## *I) Individual #1*

| | | |
|---|---|---|
| Name: | | Sex: ☐M ☐F |
| Address: | | DOB: / / |
| City: | State: | Zip: |
| Individual's social security number: / / | | |
| Date and time incident occurred: / / | at : ☐AM ☐PM (Check One) | |
| If different, when was incident discovered: / / | at : ☐AM ☐PM (Check One) | |
| # of individuals present at the time of incident: | # of staff present at time of incident: | |
| Address where incident occurred, if different from individual's address: | | |
| Is the address where incident occurred a DDA licensed site/service? ☐Y ☐N | | |

## *II) Agency Information* ***Name:***

| | |
|---|---|
| OHCQ Provider #: | Date Of Report: / / |
| OHCQ Site #: | Time of Report: : ☐AM ☐PM (Check One) |

What type of program/service is provided for this individual? ☐Community Residential ☐Day – Rehab ☐OCYF
☐Other ☐Transportation ☐SRC ☐FISS ☐Medical day ☐Vocational ☐CSLA ☐IFC

Is this a DDA licensed site? ☐Y ☐N

## *III) Agency Contact Person*

| | |
|---|---|
| Name: | Title/Relationship: |
| Address: | Phone #: ( ) - |
| City: St: Zip: Fax #: ( ) - | |
| Email Address: @ | |

## *IV) Type of Incident:* ***Check only the primary incident category that indicates the suspected or known cause of the incident: (See section V below if selecting abuse)***

| | |
|---|---|
| ☐ ER visit due to a level 3 injury | ☐ Medication error requiring treatment |
| ☐ Unplanned hospital admission | ☐ Medication error requiring hospital admission |
| Name of Hospital**:** | ☐ Level III severe injury |
| ☐ Neglect | ☐ Leave w/o notification (individual in immediate danger) |
| ☐ Theft of individual's property (> $50) | ☐ Leave w/o notification (absent > 4 hours) |
| ☐ Police Dept. visit w/ report taken | ☐ Fire Dept. visit |
| ☐ Unauthorized/inappropriate use of restraints | ☐ Chemical intervention |
| ☐ Use of restraints that result in any type of injury | |
| ☐ Other-**explain:** | |

## *V) For abuse: This incident involves:* ☐ ***Staff and individuals OR*** ☐ ***Two or more individuals***

## *Indicate Primary Category:*

| | | | |
|---|---|---|---|
| ☐ Physical abuse | ☐Use of aversive technique | ☐ Inhumane treatment | ☐ Seclusion |
| ☐ Sexual abuse | ☐ Psychological abuse | ☐ Violation of an individual's rights | |

## *VI) In cases of Death:* Location of death:

| | |
|---|---|
| DOD: / / | Was the death a result of unusual, suspicious or unnatural causes? ☐Y ☐N |
| Was death reported to a local law enforcement agency? ☐Y ☐N | Was hospice involved? ☐Y ☐N |
| Has an autopsy been requested? ☐Y ☐N | Was death anticipated? ☐Y ☐N |
| Was medical examiner's office notified? ☐Y ☐N | |
| Was EMT unit involved? ☐Y ☐N If yes, identify unit: | |

### OHCQ USE ONLY

Received date: / / Time : OHCQ investigation #:

Date incident # given to agency: / / Triage staff Initials:

Rev: 4/2005

**_VII) Briefly describe the circumstances of the incident:_** (Be certain to include those effects on persons involved and any other pertinent information that will assist in assessment.)

**_VIII) Briefly describe status of individual at the time of report:_**
(including any medical treatment needs if known)

**_IX) Witnesses to the incident:_**

| Name (Last, First) | Address | Phone # |
|---|---|---|
| | | (    )    - |
| | | (    )    - |
| | | (    )    - |

**_X) Please list all staff on duty at time of incident:_** **(Use additional pages if necessary)**

| Name | Job Title |
|---|---|
| | |
| | |
| | |

**_XI) Notifications: Please list persons notified:_** (Use additional pages if necessary)

**Family**

Does individual have family? ☐Y ☐N | Is family involved with individual? ☐Y ☐N

If individual has family, when were they notified?    /    /    at ☐AM ☐PM (check One)

Has advocate, other than family been notified? ☐Y ☐N

**Law Enforcement**

Was this incident reported to a law enforcement agency? ☐Y ☐N

If yes: Officer's name:    Jurisdiction:    Report #:

*************************************************************************************

| Name | Relationship/Agency | Date |
|---|---|---|
| | Resource Coordinator | /    / |
| | DDA Regional Office | /    / |
| | OHCQ | /    / |
| | *MDLC | /    / |
| | **CPS/APS | /    / |
| | Other | /    / |

* The following must be reported to MDLC: All Deaths, Hospital Visits, Medication Errors, Reportable Restraint Use, Reportable injury and any incident that may be the result of abuse or neglect.
**Incidents must be reported to CPS/APS per: Irregular situations - section 1A and Appendix 2A – Sections 6 & 7 of Other Agency/SRC requirements

**XII) Agency/SRC staff person completing this form: (Please print)**

Effective Date: July 1, 2005