| **Incident Information** | | | | | | |
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| INCIDENT DATE | INCIDENT START TIME | | | INCIDENT END TIME | PROVIDER NAME | |
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|  | | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  **Incident Report to DDA** | | | | |
| **Persons Involved (Per your agency policy, you may use full names or initials for other involved clients.)** | | | | | | |
| LAST NAME | | | FIRST NAME | | INCIDENT ROLE | PERSON TYPE |
|  | | |  | | **Choose an item.** | **Choose an item.** |
|  | | |  | | **Choose an item.** | **Choose an item.** |
|  | | |  | | **Choose an item.** | **Choose an item.** |
|  | | |  | | **Choose an item.** | **Choose an item.** |
|  | | |  | | **Choose an item.** | **Choose an item.** |
|  | | |  | | **Choose an item.** | **Choose an item.** |
| **Incident Details** | | | | | | |
| ANTECEDENT (WHAT HAPPENED BEFORE / LEADING UP TO THE INCIDENT) | | | | | | |

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| INCIDENT DESCRIPTION |

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| STAFF RESPONSE (WHAT DID STAFF DO IMMEDIATELY FOLLOWING / AS A RESULT OF THE INCIDENT) |

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| AS A RESULT OF THE INCIDENT, CHECK ACTIONS TAKEN / PLANNED WITHIN NEXT SEVEN (7) DAYS.  Client relocation  IISP updated  Provider initiating investigation  CSCP updated  Increased supervision  Staff reassigned  Doctor / Nurse / Pharmacy contacted  Medical assessment / treatment  Staff reassigned – no client contact  FA / PBSP written / updated  Mental health facility admission  Staff terminated  Hospital admission  Mental health referral  Staff voluntarily resigned  Other staff action: |
| DESCRIBE HEALTH AND WELFARE ACTIONS TAKEN OR PLANNED AS RESULT OF INCIDENT |

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| Were there any client injuries that required treatment beyond First Aid?  Yes  No  Describe any injuries as a result of this incident, who was injured, and type and location of injury: |

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| Is abuse, neglect, personal or financial exploitation, abandonment, or improper restraint suspected?  Yes  No If yes, explain briefly below. |

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| **Notifications by Provider** | | | |
|  | DATE NOTIFIED | PERSON / ENTITY NOTIFIED | CONFIRMATION / CASE NUMBER |
| DDA notification as required by DDA policy |  |  |  |
| Medical professional |  |  |
| Guardian / Legal Representative |  |  |
| CRU / RCS / APS / CPS |  |  |  |
| Law enforcement |  |  |  |
| Department of Health |  |  |  |
| Emergency medical / fire |  |  |  |
| Coroner / Medical Examiner |  |  |  |
| County Staff |  |  |  |
| Other |  |  |  |
| **Person Submitting Report** | | | |
| NAME | | TITLE | DATE SUBMITTED |