

UNUSUAL INCIDENT REPORT

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| DATE OF REPORT: | TIME: |
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|--|-----------------------|------------------------|---|--------|----------|
| NAME OF CLIENT (Last, First, M.I.) | | | PROVIDER NAME: | | |
| ADDRESS: | | | ADDRESS: | | |
| CITY | STATE | ZIP CODE | CITY | STATE | ZIP CODE |
| PHONE: | | | PHONE: | | |
| COUNTY OF RESIDENCE: | | | COUNTY WHERE CENTER LOCATED: | | |
| DATE OF BIRTH: | SEX: | | DATE OF ADMISSION: | | |
| | M: _____ | F: _____ | | | |
| DATE OF INCIDENT: | TIME OF INCIDENT: | CENTER LICENSE NUMBER: | NAME OF PERSON COMPLETING FORM AND TITLE: | | |
| LOCATION OF INCIDENT (Bathroom, Hall, Program Area, Outside center, etc.) | | | | | |
| DESCRIBE IN DETAIL EXACTLY WHAT HAPPENED AND ANY CIRCUMSTANCES WHICH MAY HAVE PRECIPITATED THE UNUSUAL INCIDENT: (ATTACH ADDITIONAL SHEETS IF NECESSARY) | | | | | |
| DESCRIPTION OF ANY INJURY: | | | | | |
| PHYSICIAN'S NAME & STATEMENT (if applicable): | | | | | |
| ACTION TAKEN: | | | | | |
| OTHER PERTINENT INFORMATION (Seizures, Visual Impairment, Safety Conditions, etc.) | | | | | |
| RELATIVE OR GUARDIAN NOTIFIED: | RELATIONSHIP: | ADDRESS: | PHONE: | | |
| REPORTER'S TYPED NAME: | REPORTER'S SIGNATURE: | | | TITLE: | |
| DATE MAILED TO: | | | | | |
| _____ Department of Aging | | | | | |
| _____ County MH/MR Office | | | | | |
| _____ Funding Agency (Specify) _____ | | | | | |
| DATE AND TIME NOTIFIED IF ABUSE OR SUSPECTED ABUSE OF A CLIENT; AN INCIDENT REQUIRING THE SERVICES OF A FIRE DEPARTMENT OR A LAW ENFORCEMENT AGENCY; OR CONDITION RESULTING IN CLOSURE FOR MORE THAN ONE DAY OF OPERATION: | | | | | |
| _____ Department of Aging | | | | | |
| _____ County MH/MR Office | | | | | |
| _____ Funding Agency)Specify) _____ | | | | | |