

Initial Incident Report

This report should be completed within 24 hours of an incident. Incidents that occur on Friday or over the weekend must be submitted on Monday (in person, by phone or fax). Employee injuries must first be reported on a Worker's Compensation form.

Your Name: _____ **Date of Incident:** _____ **Time of incident:** _____ AM PM

Type of Incident:

- Accident involving: Self Other Injury to: Self Other
- Witnessing instances of: Abuse Neglect Use of emergency restraint/physical management intervention
- Other: _____

People involved (check ALL that apply): Person Served Employee Family Trainee Other _____

"Incident" means any occurrence which is not consistent with the routine operation of a service or the routine care of a person served that is likely to lead to a negative effect upon the person or property of a person served, or that is likely to lead to a negative effect caused by a person served.

1. People involved in incident:

Name of person served: _____ Name of employee: _____

Name/s of additional individuals involved:

Name: _____	Relationship to person served: _____
Name: _____	Relationship to person served: _____
Name: _____	Relationship to person served: _____
Name: _____	Relationship to person served: _____

2. Location of incident: _____

3. Description of incident (including things leading up to the incident): _____

4. If applicable, describe injuries, damages and/or adverse affects: _____

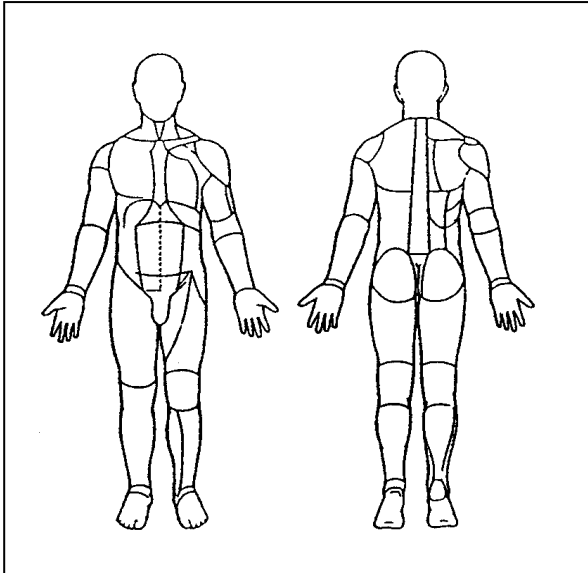
5. Immediate action taken: _____

6. If an injury occurred, circle Yes or No to the following questions for each person involved:

	Name _____	Name _____	Name _____
Was First Aid Used?	Yes / No	Yes / No	Yes / No
Was 911 called?	Yes / No	Yes / No	Yes / No
Was medical treatment necessary?	Yes / No	Yes / No	Yes / No
Was a Physician required?	Yes / No	Yes / No	Yes / No
Was the Emergency Room Used?	Yes / No	Yes / No	Yes / No
Was injury considered serious?	Yes / No	Yes / No	Yes / No
Did hospitalization occur?	Yes / No	Yes / No	Yes / No

Please list any physicians and medical facilities used: _____

Please mark on figure any bruises, cuts, scratches, marks, etc. discovered on the person served (if applicable).



7. Who was notified of this incident?

Note: If this is an unusual incident or Emergency Measure Intervention (EMI) which has occurred during non-working hours or holidays, the 24 hour obligation for DDD reporting will be met by calling 1-888-289-7177. Also, as always, please remember to contact the office to report the incident within 24 hours of occurrence.

	Name	Date	Time	Contacted by
Supervisor			<input type="checkbox"/> AM <input type="checkbox"/> PM	
Family Member/Guardian			<input type="checkbox"/> AM <input type="checkbox"/> PM	
Physician			<input type="checkbox"/> AM <input type="checkbox"/> PM	
AZA United Supervisor			<input type="checkbox"/> AM <input type="checkbox"/> PM	
Support Coordinator			<input type="checkbox"/> AM <input type="checkbox"/> PM	
Other:			<input type="checkbox"/> AM <input type="checkbox"/> PM	
Other:			<input type="checkbox"/> AM <input type="checkbox"/> PM	

Employee Signature: _____

Date: _____

Signature of Supervisor: _____

Date: _____

Signature of Administrator: _____

Date: _____

Incident Identification Number (office use only): _____