Attachment A

Sample~~~~ Internal Incident Reporting Form* ~~~~Sample

Incident Reporting Form [Name and Address of Provider]	☐ Injury ☐ Incident ☐ Close Call/Near Hit Specific Site of Incident:

REPORTER CONTACT INFORMATION

Name of Person Completing Form: (Please Print)	Title	Phone No.
Date of Incident: (mm/dd/yyyy)	Time of Incident: ☐am ☐pm ☐ unknown	Date of Discovery: (mm/dd/yyyy)	Date of Report: (mm/dd/yyyy)

INJURED PARTY INFORMATION (Complete for Injury and Death)

If no injury, check box and skip this section. ☐ No Injury	Injured Party's Name: ☐ Consumer ☐ Staff ☐ Visitor ☐ Other (specify):		Injured Party's Contact Information:	
Waiver Recipient? ☐ Yes ☐ No	If Waiver recipient, Waiver Type: Medicaid Number:		If consumer, Case Management CSB:	
Nature of Injury/Illness:	☐ Bite	☐ Death	☐ Ingestion of Substance	☐ Seizure/Convulsion
☐ Abrasion/Cut/Scratch	☐ Burn	☐ Decubitus Ulcer	☐ Laceration	☐ Sprain
☐ Adverse Reaction	☐ Choking	☐ Dislocation	☐ Medication Error	☐ Suicide Attempt
☐ Aspiration Pneumonia	☐ Constipation/Bowel Obstruction	☐ Fracture	☐ Overdose	☐ Suicide
☐ Assault by Client	☐ Contusion/Hematoma	☐ Fall	☐ Redness/Swelling	☐ Other (specify)
Body Part Injured: (describe)				

Treatment: ☐ Emergency ☐ Non Emergency	Name and Address of Treating Physician:		Description of Medical Treatment Provided and Findings:	
Hospitalization? ☐ Yes ☐ No	Date of Medical Attention: (mm/dd/yyyy)	Time of Medical Attention: ☐am ☐pm ☐ unknown		
Precipitating Event:	☐ Assault by Client	☐ Restraint	☐ Self-injurious Behavior	☐ Other: (specify)
☐ Abuse Allegation	☐ Neglect Allegation	☐ Seclusion	☐ Unexplained	

DEATH INFORMATION

Type of death: ☐ Natural ☐ Accident ☐ Intentional	☐ Expected ☐ Unexpected Referred to Medical Examiner? ☐ Yes ☐ No Is autopsy to be performed? ☐ Yes ☐ No Cause (from Death Certificate):	External Notifications Made: ☐ Department of Health Professions ☐ Department of Social Services ☐ Local Law Enforcement Agency	☐ State Police ☐ Department of Health ☐ Other: (specify)

OTHER INFORMATION

If Abuse or Neglect Allegation, was an investigation initiated? ☐ Yes ☐ No	If yes, date initiated: (mm/dd/yyyy)
Authorized Representative: ☐ Yes ☐ No	AR Notified? ☐ Yes ☐ No
Signature of Person Completing Form:	Date
Signature of Risk Manager:	Date
☐ Litigation anticipated	Reason:

* This form is for internal use only; it does not replace CHRIS reporting. Licensed providers must report incidents to the DBHDS via CHRIS.