MENTAL HEATLH AND DEVELOPMENTAL DISABILITIES SERVICES DIVISION
STATE-OPERATED COMMUNITY PROGRAM

Incident Report

Res. ☐ Home ☐
Voc. ☐ Community ☐

Name: _____
(Last) *(First)*
DOB: _____

Date Incident Occurred: ____/____/____
Time Incident Occurred: ____:____
Date Report Initiated: _____/_____/____

A) What happened before the incident?_____

_____

_____

B) What happened during the incident?_____

_____

_____

_____

_____

_____

C) What intervention did you do? Result?_____

_____

_____

Program Personal Restraint ☐

Emergency Personal Restraint ☐
Emergency Psychotropic Medication ☐
Program Administration Authorization:
Time notified:_____ Time approved:_____
Program Administrator Name:

Were there other interventions prior to the restraint?
Yes (list above): ☐ No: ☐
How long was the person in restraint?
_____Minutes / _____Seconds
Type of restraint:_____
Staff Administering Restraint:_____

How long was the person in restraint?
_____Minutes / _____Seconds
Type of restraint:_____
Staff Administering Restraint:_____

How long was the person in restraint?
_____Minutes / _____Seconds
Type of restraint:_____
Staff Administering Restraint:_____

Complete this section of the IR if an injury occurred:

Type of injury:_____
Location of injury:_____
Size (inches):_____
Treatment:_____

Name of other staff involved:_____

Name and title of person completing IR:_____

Review, analysis, and preventative action: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How should the incident be classified (check all that apply):

☐ Death	☐ Injury	☐ Self-Injurious Behavior
☐ Sudden Illness	☐ Hospitalization	☐ Pica
☐ Emergency Aid Needed (911)	☐ Property Destruction	☐ Incident with the Public
Medical ☐ Police ☐ Fire ☐	☐ Unusual Incident	☐ Missing
☐ Suicide Attempt ☐ Threat ☐	☐ Emergency Restraint	☐ Aggression
☐ Choking	☐ Program Restraint (approved BSP)	☐ Suspected Abuse/Neglect
☐ Emergency Psychotropic Medication	☐ Other _____	☐ Referred for Investigation (OIT)

Site Manager Signature:_____Date:_____

Additional Comments:

_____

Program Administrator Review & Signature:_____Date:_____

Case Manager Notification Date: _____ Method: _____
Supervisor Notification Date: _____ Method: _____
Program Administrator Date: _____ Method: _____

Client Name: _____ Date: _____ Time: _____

Section	Incident Report Continuation