| **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 |
| 1.
 |  | **Choose an item.** | **Choose an item.** |
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 |  | **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 [ ]  NoDescribe 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 [ ]  NoIf 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 |  |  |  |
| **Person Submitting Report** |
| NAME | TITLE | DATE SUBMITTED |