# Incident Reporting Form

[Name and Address of Provider]

**REPORter CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Name of Person Completing Form:</th>
<th>Title</th>
<th>Phone No.</th>
</tr>
</thead>
</table>

**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

**Waiver Recipient?**

- [ ] Yes
- [ ] No

If Waiver recipient, Waiver Type:

- [ ] Medicaid Number:

**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:**

**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):

**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.*