The New Beginnings

Incident Report

Individual's Name:	Today's Date:
Date of Incident:	Time of Incident: □ AM □ PM

Location of Incident: □ Home □ Day Program □ Work
□ Other:____

List other Individual's involved (First and Last Name): □ None
1. 2. 3.

List any staff involved (First and Last Name): □ None
1. 2. 3.

Person Filling Out Report(Print First and Last Name):

Incident Details:

Type of Incident: Injury___ Behavioral___ Med Error___ Other_____________

If Med Error, Please fill out third page

Level of Incident: Minor___ Moderate___ Serious___ Other___

Medical Attention Needed(If Injured): Yes___ No___

Does Individual Have A BSP? Yes___ No___ Was BSP Followed? Yes___ No___
Explanation if Necessary:____
____
____

Was (CPI) physical restraint used? Yes___ No___ If yes please explain/Describe type of CPI restraint used:
____
____
____

Notifications:

	Title and Name	Spoke With	Message Left	Comments
□	House Manager -	□Yes □No	□Yes □No	
□	Case Manager -	□Yes □No	□Yes □No	
□	Guardian -	□Yes □No	□Yes □No	
□	Service coordinator -	□Yes □No	□Yes □No	
□	Behavior Therapist-	□Yes □No	□Yes □No	
□	Agency Nurse-	□Yes □No	□Yes □No	
□	On Call (615-4931) -	□Yes □No	□Yes □No	
□	Other -	□Yes □No	□Yes □No	

Description of Incident
Before:
During:
After Incident/Follow Up:
Staff Signature: **Date:**
Agency Nurse Involvement(NURSE USE ONLY):
CAIR Required? □ Yes □ No If yes please attach CAIR Form.

Incident Coordinator Signature: _________________________ Date: _______________

ROUTING:

I.C. Forward to S.C.: Initials ______________ Date ______________

S.C. Forward to Nurse: Initials ______________Date ______________

Nurse Forward to I.C.: Initials ______________ Date______________

Med Error Description

Name of Medication:	**Dosage:**
Scheduled Time:	**Individual Name:**

Type of Error:

- ☐ **Wrong Person**
- ☐ **Wrong Route**
- ☐ **Wrong Dose**
- ☐ **Wrong Time**
- ☐ **Documentation Error**
- ☐ **Missed Medication**

Explain Error:

____
____
____

On Call Nurse Notified? Yes_____ No _____

On Call Nursing directive or Corrective Action Response:

____
____
____

Staff responsible for administering medications (Please print):

Name: ________________________________ Shift Worked: ________________________

For Nurse Use Only

Nurse Follow Up: **Corrective Action Needed? ____Yes ____No**

____
____
____

____________________________________ ____________________________________
Nursing Signature **Date**