UNUSUAL INCIDENT/INJURY REPORT

INSTRUCTIONS : NOTIFY LICENSING AGENCY, PLACEMENT AGENCY AND RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY.

SUBMIT WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE.

IAME OF FACILITY			FACILITY FILE NUMBER			TELEPHONE NUMBER
ADDRESS			CITY, STATE, ZIP			
CLIENTS/RESIDENTS INVOLVED	DATE O	CCURRED	AGE	SEX	DATE OF ADMISSION	
			<u> </u>	. <u>.</u>	· · · ·	
 □ Unauthorized Absence □ Aggressive Act/Self □ Sexual 	nt Abuse	 Rape Pregnanc 		njury-Ac	cident hknown Origin	 Medical Emergency Other Sexual Incident
□ Aggressive Act/Sein □ Sexual		 I regnanc Suicide At 			om another Clie	
□ Aggressive Act/Staff □ Psycholog	gical	☐ Other	•		om behavior epi	
\Box Aggressive Act/Family, Visitors \Box Financial	-				c Outbreak	Property Damage
□ Alleged Violation of Rights □ Neglect				lospitali	zation	□ Other <i>(explain)</i>
DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PEANY INJURIES:	ERPETRATOR, NAT	URE OF INCIDENT, A	NY ANTECEDENTS	S LEADING	UP TO INCIDENT AND	HOW CLIENTS WERE AFFECTED, INCLUDING
PERSON(S) WHO OBSERVED THE INCIDENT/INJURY:						
EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CO	NTACTED):					

MEDICAL TREATMENT NECESSARY? 🗌 YES 🗌 NO 🛛 IF YES, GIVE NATURE OF TREATMENT:					
WHERE ADMINISTERED:	ADMINISTERED BY:				
FOLLOW-UP TREATMENT, IF ANY:	-				
ACTION TAKEN OR PLANNED (BY WHOM AND ANTICIPATED RESULTS:					
LICENSEE/SUPERVISOR COMMENTS:					
NAME OF ATTENDING PHYSICIAN					
REPORT SUBMITTED BY:		DATE			
REPORT REVIEWED/APPROVED BY:		DATE			
AGENCIES/INDIVIDUALS NOTIFIED (SPECIFY NAME AND T					
AGENCIES/INDIVIDUALS NOTIFIED (SPECIFY NAME AND T	ELEPHONE NOMBER)				
	_ _ ADULT/CHILD PROTECTIVE SERVICES				
LONG TERM CARE OMBUDSMAN	PARENT/GUARDIAN/CONSERVATOR				
	PLACEMENT AGENCY				