

**San Diego Regional Center
SPECIAL INCIDENT REPORT**

(For SDRC Vendors and Long Term Care Facilities)

(Retain copy of this report in consumer's file. Notify CCL/SDRC within 24 hours of occurrence of incident and submit to SDRC written report within 48 hours and to CCL within 7 days of occurrence)

TO: _____, SDRC Service Coordinator

SECTION I

Consumer's Name: _____ UCI#: _____
 Date of Birth: _____ Age: _____ Gender: M ___ F ___
 Date of Incident: _____ Time of Incident: _____
 Date Reported to SDRC/ Lic. Agency: _____ Date of Admission: _____
 Location of Incident: _____

- Home of Family /Consumer Consumer's Residence Day Program In-Patient Hospice Job Site
 In Transit (Vehicle) ER of Acute Hospital Community Acute Hospital, not ER School
 Other (please specify) _____

Please indicate below the name of the place where the incident occurred. (Ex: name of transportation, name of job site, name of Foster Home):

SECTION II

TYPE OF SPECIAL INCIDENT

COLUMN A	COLUMN B	COLUMN C
<input type="checkbox"/> Death - regardless of cause or location <input type="checkbox"/> Missing person-law enforcement notified <u>Consumer a victim of crime:</u> <input type="checkbox"/> Burglary <input type="checkbox"/> Larceny <input type="checkbox"/> Aggravated Assault <input type="checkbox"/> Robbery <input type="checkbox"/> Rape or attempted rape <u>Reasonably Suspected Neglect</u> <u>including failure to:</u> <input type="checkbox"/> Provide medical care <input type="checkbox"/> Prevent malnutrition and dehydration <input type="checkbox"/> Protect from health/safety hazard <input type="checkbox"/> Assist in personal hygiene <input type="checkbox"/> Provide food or clothing <u>Reasonably Suspected Abuse or Exploitation:</u> <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Fiduciary <input type="checkbox"/> Mental/Emotional <input type="checkbox"/> Physical/Chemical Restraint	<u>A serious injury or accident requiring medical treatment including:</u> <input type="checkbox"/> Fracture <input type="checkbox"/> Burn <input type="checkbox"/> Any Medication Error <input type="checkbox"/> Dislocation <input type="checkbox"/> Puncture Wounds <input type="checkbox"/> Internal Bleeding <input type="checkbox"/> Medication Reaction <input type="checkbox"/> Bites that break the skin <input type="checkbox"/> Lacerations requiring staples/sutures <u>Unplanned/Unscheduled hospitalization:</u> <input type="checkbox"/> Respiratory Illness <input type="checkbox"/> Seizure Related <input type="checkbox"/> Diabetes Related <input type="checkbox"/> Cardiac Related <input type="checkbox"/> Internal Infection <input type="checkbox"/> Wound/Skin Care <input type="checkbox"/> Nutritional Deficiency/Dehydration <input type="checkbox"/> Involuntary Psychiatric Hospitalization	<input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Diagnosis of Communicable Disease <input type="checkbox"/> Prone/Supine Containment <input type="checkbox"/> Violation of Consumer's Rights <input type="checkbox"/> Aggressive Act to Self <input type="checkbox"/> Aggressive Act to another consumer <input type="checkbox"/> Aggressive Act to Visitors/Family/Staff <input type="checkbox"/> Medical Emergency/ER Visit/Not Hospitalized <input type="checkbox"/> Property Damage <input type="checkbox"/> Fire/Explosion Occurring in Premises <input type="checkbox"/> Poisoning <input type="checkbox"/> Infestation of parasites or vectors <input type="checkbox"/> Others (Specify) _____

SECTION III

Description of Special Incident/Death

(Please attach a separate page to capture all of the information. Please remember we need to be able to read this report)
(Include conditions prior to incident/death, any consumer/staff involved.)

Description of Alleged Perpetrator, if applicable: Not Applicable

Name: _____ **Relationship to Consumer:** Relative/Family member
 Height: _____ Another Consumer Non-Vendor/Employee of non-vendor
 Weight: _____ Self Other Individual known to consumer
 Age: _____ Unknown Vendor/Employee of Vendor

Medical Treatment Provided to Consumer? Yes No
If Yes, where? _____ Hospital Admission ER Urgent Care On Site
 Nature of Injury/ Treatment _____

Follow-up Treatment, if any: _____
 Name and Phone Number of Physician: _____
 Name of Mortician/Funeral Home (if applicable) _____

SECTION IV

Action(s) taken by Vendor in response to Special Incident:

- | | | |
|---|--|---|
| <input type="checkbox"/> Staff Training | <input type="checkbox"/> Policies Revised | <input type="checkbox"/> Staff terminated |
| <input type="checkbox"/> Referral to Clinical Service | <input type="checkbox"/> Planning Team Meeting | <input type="checkbox"/> Staff suspended |
| <input type="checkbox"/> Reported to other agencies | | |
| <input type="checkbox"/> Other (Please specify) _____ | | |

Plan to prevent further occurrence / Anticipated result: _____

Comments: _____

Name/Address/ Telephone Number of any witness to the incident (if any): _____

Consumer is: Verbal Non-Verbal Ambulatory Non-Ambulatory

SECTION V

Parties/Agencies Notified:

<u>Party/Agency</u>	<u>Name of Contact</u>	<u>Phone #</u>	<u>Date Notified</u>
<input type="checkbox"/> APS/CPS	_____	_____	_____
<input type="checkbox"/> Law Enforcement	_____	_____	_____
<input type="checkbox"/> LTC Ombudsman	_____	_____	_____
<input type="checkbox"/> CCL/HCL	_____	_____	_____
<input type="checkbox"/> Coroner	_____	_____	_____
<input type="checkbox"/> Parent/Conservator/Guardian	_____	_____	_____
<input type="checkbox"/> Care Provider/Residence	_____	_____	_____
<input type="checkbox"/> Others (Please specify) _____	_____	_____	_____

SECTION VI

REPORT WRITTEN BY:

Name: _____
 Title and signature _____

Facility/Vendor Name: _____
 Vendor Address: _____

REVIEWED BY:

Name: _____
 Title and Signature _____
 Date: _____

Vendor Number: _____
 Phone Number: _____
 DHS/CCL License # _____

Please FAX to SDRC

SDRC Fax #: _____

SECTION VII

FOR SDRC USE ONLY

Action(s) taken/planned by SDRC:

- | | | |
|--|---|--|
| <input type="checkbox"/> Increased Case Management | <input type="checkbox"/> Increased Clinical Service | <input type="checkbox"/> Additional Support and Services |
| <input type="checkbox"/> Plan of Corrective Action | <input type="checkbox"/> Consumer Relocated | <input type="checkbox"/> Additional Services/Supports Declined |
| <input type="checkbox"/> Training and Technical Assistance | <input type="checkbox"/> Planning Team Meeting | <input type="checkbox"/> Sanctions Imposed |
| <input type="checkbox"/> Participate in Discharge Planning | | |
| <input type="checkbox"/> Other _____ | | |

Notification of agencies confirmed/verified: Yes _____ No _____

Comments: _____

SERVICE COORDINATOR: _____

Signature: _____

Unit #: _____

Phone #: _____

Date SIR received: _____

Date sent to SIR Coordinator: _____

Service Coordinator to FAX both sides of this form to SIR Coordinator, if Special incident reportable to DDS.

FAX Number: (858) 503-4443