LifeSpan Family Services of PA
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INCIDENT REPORT
CONFIDENTIAL

INSTRUCTIONS: Reports must be written in a specific, objective, and factual manner. Events should be listed in chronological order and include follow-up actions. The report is classified as confidential. The incident report must be documented completely and submitted within 24 hours of when the incident occurred. Please write N/A/ if a section doesn't apply.

A. SPECIFICS OF INCIDENT

1. **Name of Individual Involved** **First** **Last**	2. X Client ❑ Staff ❑ Other(specify)	3. **Social Security #** 4. **Date of Birth**
4. **Gender** ❑ Male Female	5. **Axis I Diagnosis (if applicable)** ______________________	6. **Level of Retardation (if applicable)** ___Mild ___ Moderate ___Severe ___ Profound
7. **Street Address**	8. **City/State/Zip**	9. **Phone Number**
10. **Foster Family**	11. **Address and phone (if different then #7)**	12. **Incident location:** X Foster Home ❑ Home Visit ❑ Community ❑ Other: ___________
13. **Date of Incident/Date Notified**	14**. Time of Incident/Time Notified**	15. **Incident Point Person (initial reporter)**

16. **Name of Other Involved/Witness** ___ Client ___ Staff ___Other:	17. Contact Phone Number

B. DESCRIPTION/DETAILS OF INCIDENT Please **PRINT** Clearly (attach additional pages if necessary)

Print Name /title/position	Signature	Date of Signature
______________________	___________________________	_______________________
Review by: (print)	Signature	Date Reviewed:
______________________	___________________________	_______________________

Incident Follow up:

Date Incident Closed:

__________________ ______

Date Initials

C. TYPE OF INCIDENT

If injury:

- ❑ No Medical attention
- ❑ First Aid Only
- ❑ ER Visit
- ❑ Hospital Admission

Circle and put a 1 and 2 next to the description for the Primary (1) and Secondary(2) types of incidents:

Abuse Physical Psychological Sexual Verbal	Neglect
Client Behavior	Police Involvement
Alleged Criminal Act/Theft/Misuse of Funds	Potential Negative Community Involvement
Client Restraint Physical Mechanical Chemical	Property/Equipment Damage
Death	Outbreak of Communicable Disease
Emergency Closure/Relocation	Rights Violation
Falls	Refusal of Prescribed Treatment
Fire	Sexual Relations
Hospitalization- Medical	Suicide Threat/Attempt/Actual
Hospitalization- Psychiatric	Vehicle Accident
Injury (please complete injury information)	Unexplained Absence/AWOL
Medical/Emergency Problem/ER Visit	Unscheduled Inspections
Medication Error Wrong Med Wrong Dose Omission	Unsafe Conditions/Security Other- Specify

FURTHER EXPLAINATION OF ABOVE: (IF NEEDED)

Individual Involved:	Date of Incident:

D. NOTIFICATION/FOLLOW-UP CHECKLIST * L=Letter; F=Fax; E=Email; V=Verbal

INTERNAL	Notified Y/N	Date	Time	How* L/F/E/V	Name of Person Notified	Title	Notified by (Initials)
Director							
Manager							
Workers Comp							
Other:							

EXTERNAL	Notified Y/N	Date	Time	How* L/F/E/V	Name of Person Notified	Title	Notified by (Initials)
Family/Guardian							
County C & Y							
County JPO							
Regional CYS							
Childline							
Placing Agency							
Other:							

E. INVESTIGATION INFORMATION (As Applicable)

1. Name of Investigator	2. Title of Investigator	3. Telephone Number
4. Investigation Status ❑ Open ❑ Pending Follow-up Report ❑ Investigation Complete ❑ Investigation Re-opened ❑ Closed- Pending Final Report ❑ Closed- Final Report Complete ❑ Other (specify below)	5. Investigation Outcome ❑ Confirmed ❑ Unconfirmed ❑ Can not be determined/inconclusive	6. Corrective Action/ Recommendations ❑ Behavior/Tx Plan modified ❑ Staff/Supervision changed ❑ Client relocated ❑ Staff disciplined ❑ Staff relocated ❑ Staff training/retraining ❑ Staff temporarily suspended ❑ Staff terminated ❑ Restitution of funds/property ❑ Other (specify below)

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Incident Report Attachment

INJURY

(only fill out if injury is noted)

F. SPECIFICS OF INCIDENT

1. Name of Consumer Involved	2. Name of Staff Involved	3. Other
4. Date of Incident: Date Observed:	5. Day of Week	6.Time of Incident: Time Observed:

I. COMPLETE THE FOLLOWING FOR ALL INJURIES

Was the Injured Taken For medical Treatment? ❑ Yes ❑ No	If so, where?
Treatment: ❑ No Treatment Required ❑ First Aid ❑ PCP Visit ❑ ER Visit ❑ Hospital Admission	

II. COMPLETE FOLLOWING STAFF INJURY

Referred to Physician's Panel? ❑ Yes ❑ No	Release/Waiver Attached? ❑ Yes ❑ No	Normal Shift Start Time	Social Security
Married ❑ Yes ❑ No	Number of Children	Home Address	Phone
Were you absent from work due to the incident? ❑ Yes ❑ No		In, no was it recommended by the agency to seek medical attention? ❑ Yes ❑ No	

III. DESCRIPTION OF INJURY/MEDICAL TREATMENT (MUST BE COMPLETED WHEN INJURY OCCURS TO ANYONE INVOLVED INCIDENT)

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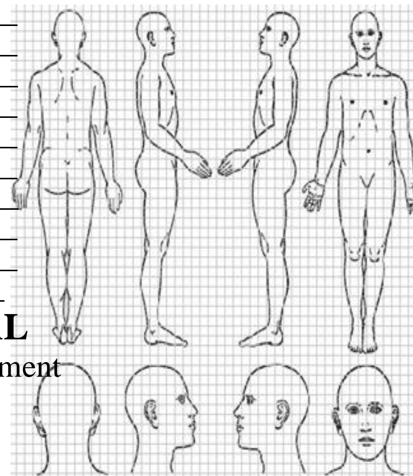

CONFIDENTIAL

Incident Report Attachment

POLICE INVOLVEMENT
(Only fill out if applicable)

F. SPECIFICS OF INCIDENT

1. Name of Consumer Involved	2. Name of Staff Involved	3. Other
4. Date of Incident: Date Observed:	5. Day of Week	6.Time of Incident: Time Observed:

I (a) POLICE INFORMATION

Police Report Being Filed?
- ❑ Yes
- ❑ No

Officer's Name:	Officer's Name:	Officer's Name:
Police Agency:	Police Agency:	Police Agency:
Badge Number:	Badge Number:	Badge Number:
Address:	Address:	Address:
Phone Number:	Phone Number:	Phone Number:

II (a) WITNESS INFORMATION

Witness 1	Witness 2	Witness 3
Name:	Name:	Name:
Address:	Address:	Address:
Phone Number:	Phone Number:	Phone Number:

III (a) DECRIPTION OF POLICE INVOLVEMENT

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IV. WITNESS STATEMENTS

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If possible, get signed witness statements

Name/Title:	Signature:	Date:

(Only use if applicable)

F.SPECIFICS OF INCIDENT

1. Name of Consumer Involved	2. Name of Staff Involved:	3. Other:
4. Date of incident Date Observed:	5. Day of Week:	6. Time of Incident: Time Observed:

I (b) POLICE INFORMATION

Police Report Being Filed? ❑ Yes ❑ No	
Officer’s Name:	Officer’s Name:
Police Agency:	Police Agency:
Badge Number:	Badge Number:
Address:	Address:
Phone Number:	Phone Number:

II (b) Vehicle Information

Vehicle 1	Vehicle 2
License Plate #:	License Plate #:
VIN #:	VIN #:
Insurance Co:	Insurance Co:
Phone:	Phone:

III (b) WITTNESS INFORMATION

Witness 1 Name:	Witness 2 Name:
Address:	Address:
Phone Number:	Phone Number:

DESCRIPTION OF ACCIDENT

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