



Incident Report

Date of Incident:

Supported Person:

Start Time:

End Time:

Staff Reporting:

Location of Incident:

Staff Involved:

Type of Incident (Check all that apply)

- | | | | | |
|--------------------------------------|---|--|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Medication | <input type="checkbox"/> Physical Behavior | <input type="checkbox"/> Inappropriate Sexual Behavior | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> Self Injury | <input type="checkbox"/> PRN (OTC) | <input type="checkbox"/> Verbal Behavior | <input type="checkbox"/> Protocol/ Policy Breach | |
| <input type="checkbox"/> Injury | <input type="checkbox"/> PRN (Prescription) | <input type="checkbox"/> AWOL | <input type="checkbox"/> Other (specify): | |

Description of Incident

Describe What Happened (Provide specifics about the Type of Incident identified above)

What Happened That Triggered The Incident (Document anything that may have caused the behavior to occur)

What Was Staff's Initial Response (Describe staff's initial response, outcomes from the behavior, and follow-up required)

Did Staff Refer To A Specific Document? (indicate any procedure/ policy referenced)

Was a Restrictive Procedure Used? Yes No Who Authorized:

- If "Yes" describe:
- PRN (Medication and Dose)
 - Restraint (Physical)
 - Restricted Access (Items/Activities/People/Etc.)
 - Other (Specify)

Who Has Been Notified

- Management Team Leader On-coming staff Guardian Doctor Police/Ambulance
- Other (specify)

Instructions Given: (Describe any instructions given, and by whom, should the incident recur)

Signature:

Staff:

Print Name Signature Date

Administration:

Print Name Signature Date

Office Use Only

Comments/Follow-up/Recommendations:

- Guardian PDD (Critical) Follow-up Completed Health and Safety Risk Assessment File Doctor