SPECIAL INCIDENT REPORT FOR ALL VENDORS

TO BE E-MAILED OR FAXED TO SAN ANDREAS REGIONAL CENTER
(Within 24 hours of the incident)

Consumer's Name: **UCI #:**	**Date of Report:**
Consumer's Address:	**Sex:** Male Female
Vendor or Agency Name:	**Service Coordinator:**
Conservator/Guardian name (if applicable):	**CCL Facility Number:**
Name of person reporting:	**Position at agency:**

TYPE OF INCIDENT
(Check all that apply)

☐ **Injuries Requiring Treatment Beyond First Aide**
- ☐ Burns that require medical treatment beyond first aide
- ☐ Medication reactions
- ☐ Bites that break the skin/ require treatment
- ☐ Internal bleeding
- ☐ Puncture wounds requiring treatment

☐ **Medical Need/Accident/Other:**
- ☐ Fractures
- ☐ Injury-Accident/Dislocation
- ☐ Lacerations requiring sutures/ staples/glue
- ☐ Medication Errors
- ☐ Disease Outbreak
- ☐ Injury-Unknown origin
- ☐ Injury from seizure
- ☐ Injury from another consumer
- ☐ Injury from behavior episode
- ☐ Choking
- ☐ Other
- ☐ Condition Requiring Medical Intervention
- ☐ Drug/Alcohol Abuse
- ☐ Emergency Room Visit
- ☐ Seizures
- ☐ Theft by a Consumer
- ☐ Community Safety
- ☐ Law Enforcement Involvement
- ☐ EPS-Psych Emergency Team-No Hospital Admission
- ☐ Pregnancy
- ☐ Planned Hospitalization
- ☐ Voluntary Psych Admission

☐ **Suspected Abuse/Exploitation**
- ☐ Alleged Consumer Financial Abuse
- ☐ Alleged Physical Abuse
- ☐ Alleged Sexual Abuse
- ☐ Alleged Emotional/Mental Abuse
- ☐ Alleged Physical/Chemical Restraint
- ☐ Alleged Abuse-Other
- ☐ Alleged Violation Of Rights

☐ **Suspected Neglect**
- ☐ Failure to Provision of Food/ Clothing/ Shelter
- ☐ Failure to Assist in Personal Hygiene
- ☐ Failure to Prevent Dehydration
- ☐ Failure to Protect Health/Safety Hazards
- ☐ Failure to Provide Medical Care
- ☐ Failure to Provide Care Elder/Adult
- ☐ Failure to Prevent Malnutrition
- ☐ Alleged Neglect-Other

☐ **Unauthorized Absence**
- ☐ Missing Person Law Notified
- ☐ Unauthorized Absence-Law Not Notified

☐ **Unplanned Hospitalizations**
- ☐ Involuntary psychiatric admission
- ☐ Nutritional deficiencies
- ☐ Cardiac
- ☐ Diabetes
- ☐ Internal infection
- ☐ Respiratory illness
- ☐ Seizures
- ☐ Wound/skin care
- ☐ Other

☐ **Victim of Crime**
- ☐ Aggravated assault
- ☐ Burglary
- ☐ Larceny
- ☐ Personal Robbery
- ☐ Rape or Attempted Rape

☐ **Aggressive Acts**
- ☐ Aggressive act to another consumer
- ☐ Aggressive act to family/visitor
- ☐ Aggressive act to self
- ☐ Aggressive act to staff
- ☐ Severe Verbal Threats
- ☐ Suicide Attempt
- ☐ Suicide Threat
- ☐ Other Sexual Incident
- ☐ Property Damage
- ☐ Fire Setting
- ☐ Aggressive Act Involving a Weapon

☐ **Death**

Incident date ☐ Definitive ☐ Approximate	**Time of Incident** ☐ Definitive ☐ Approximate
Date incident reported to RC	**Medical Care/Treatment Required.** ☐ Yes ☐ No

Relationship of alleged perpetrator to consumer
- ☐ Unknown
- ☐ Self
- ☐ Vendor or Employee of Vendor
- ☐ Non-Vendor or Employee of Non-Vendor
- ☐ Another Consumer
- ☐ Relative/Family Member
- ☐ Individual known to consumer (Not a provider or another consumer)
- ☐ Not applicable

Incident location
(Check only one)

☐ Acute hospital–not ER	☐ Job site	☐ Day program
☐ Acute hospital–ER	☐ Out of home respite	☐ Consumer's residence
☐ Day care/ Intervention program	☐ Community setting	☐ Hospice
☐ Psychiatric treatment center	☐ Home of family	☐ Jail or related setting
☐ SNF	☐ In transit	☐ Pubic school
☐ Other	☐ Sub-acute or pediatric sub-acute	☐ Rehabilitation facility

Person/Agency responsible for consumer at time of incident

☐ Vendor	☐ Residential	Name:
☐ Parent/Family	☐ Day Program	Address:
☐ Other		City/Zip:
		Telephone:

Other agencies notified by person/agency making this report

☐ Community Care Licensing	☐ DHS Licensing & Certification
☐ Child Protective Services	☐ Adult Protective Services
☐ Parent/Guardian/Conservator	☐ Long-Term Care Ombudsman
☐ Police/Law Enforcement	☐ Other Specify
☐ Coroner	

Description of incident

Attending Physician's name, findings, and treatment:

Specific preventative action taken or planned:

Disposition:

Complete Only if Incident Type is Death

Describe the circumstances of the consumer's death/nature of medical treatment and where administered

Other comments or information regarding death (Please include all psycho-social information)

Type of Death

- ☐ ***Disease Related***
- ☐ ***Unknown***

Non-Disease Related

- ☐ Homicide
- ☐ Accident
- ☐ Suspected Substance Abuse
- ☐ Catastrophic Event (Fire, Flood)
- ☐ Other (specify)
- ☐ **Suicide**
- ☐ **Alleged Abuse/I**