HARBOR REGIONAL CENTER
Service Provider Special Incident Report
Fax: (310) 540-0756 or email: SIRS@harborrc.org
Reports must be submitted within 24 hours

Client Name:____ **DOB:**___________ **UCI#:**___________

HRC Service Coordinator:____

Service Provider:____ **Vendor #:**_____________________

Date of Incident:____ **Time of Incident:**___________________

Place of Incident:

Hospital ☐ Client's Residence ☐ Client's Day Program ☐ Family Home ☐

In Transit ☐ Emergency Room ☐ Other (specify) ☐ _______________________________________

INCIDENT TYPE (check all that apply):

☐ **Client Death:**

Where did the Client die? Hospital ☐ Client's Residence ☐ Service Provider Site

Other ☐ ____

Official Cause of Death:____ Cause Unknown ☐

☐ **Client was the Victim of a crime:**

Was the crime reported to the police? Yes ☐ No ☐

Briefly describe the crime?

☐ **Client was Admitted to the Hospital:**

Was the client in the hospital **for more than 24 hours**? Yes ☐ No ☐

What was the reason for admission? ***involuntary*** psychiatric hold (5150) ☐ respiratory illness ☐

diabetes ☐ seizure ☐ wound/skin care ☐ heart problem ☐

nutritional deficit ☐ internal infection ☐ Other ☐ _______________________________________

Briefly describe what happened that resulted in admission to the hospital:

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☐ **Client Has Had a Serious Injury or Accident:** Yes ☐ No ☐

Was medical treatment **beyond first aid required?** Yes ☐ No ☐

Describe the injury/accident and the treatment provided:

D id anyone else witness the incident? Yes ☐ No ☐

Name & contact information (phone or email) for the witness if available? ________________________

Did the client receive any medical help? No ☐ Yes ☐ *If yes,* what kind of medical help did the client get?

☐ **Missing Client:**

Has a **missing person report been filed** with law enforcement: Yes ☐ No ☐

How long has client been missing: ____

☐ **Physical Abuse of Client:**

Do you have **evidence or solid reason** to believe that the client has been physically abused? Yes ☐ No ☐

Describe:

☐ **Sexual Abuse of Client:**

Do you have **evidence or solid reason** to believe that the client has been sexually abused? Yes ☐ No ☐

Describe:

☐ **Medication Error:**

Was the client's medication given incorrectly, or not at all? Yes ☐ No ☐

Describe: *(refusing to take medication is not a special incident)*

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☐ **Financial Abuse of Client:**

Do you have **evidence or solid reason** to believe the client's money has been stolen or misused? Yes ☐ No ☐

Describe:

☐ **Physical or Chemical Restraint of Client:**

Do you have **evidence or solid reason** to believe that someone has used force or medication to control the client? Yes ☐ No ☐

Describe:

☐ **Emotional/Mental Abuse of Client:**

Do you have **evidence or solid reason** to believe that someone has emotionally or mentally abused the client? Yes ☐ No ☐

Describe:

☐ **Neglect of Client:**

Do you have **evidence or a solid reason** to believe that **someone responsible for the care and supervision** of the client has failed to provide for his/her physical needs, personal hygiene, food, clothing, shelter, or failed to protect him/her from harm? Yes ☐ No ☐

Describe:

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--------------------**For All Incidents, please complete the following information**--------------------

Describe what happened and what did you do to help the client?

Who else did you tell? (check all that apply): Community Care Licensing (DSS) ☐

Licensing & Certification (DHS) ☐ Parent/Guardian/Conservator ☐ Physician/Hospital ☐

Police/Sheriff ☐ County Coroner ☐ Other (who?) ☐:___________________________________

Your Name:

Title: **Telephone Number:**

Please use this space below to add any other information you think is important about the special incident: