|  |  |  |
| --- | --- | --- |
| **Individual’s Name:** | **DOB:** | **UCI#:** |
| **HRC Service Coordinator:** |
| **Service Provider Name:** | **Vendor #:** |
| **Date Incident Occurred:** | **Time of Incident:** |
| **Date Vendor Learned of Incident:** |  |
| **Location of Incident:**  |
|  Hospital **□**  | Client’s Residence **□** | Client’s Day Program **□** | Family Home **□** |
|  In Transit  **□**  | Emergency Room **□**  | Other (specify) **□**  |

**INCIDENT TYPE (check all that apply):**

**□ Death:**

|  |
| --- |
| Official Cause of Death:  |

**□ Victim of a crime:**

|  |  |  |
| --- | --- | --- |
| Was the crime reported to the police? | Yes □  | No □  |
| Police Department: |
| Report Number: |

 **□ Admitted to the Hospital for more than 24 hours:**

|  |
| --- |
| Admitting Diagnosis: |

**□ Individual has a serious injury or accident requiring treatment beyond first aid.**

**□ Missing Individual:**

|  |
| --- |
| Police Department: |
| Report Number: |
| How long has the individual been missing?  |

**□ Abuse of the Individual:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Physical **□**  |  Sexual **□** | Financial **□** | Chemical Restraint **□** | Emotional **□** |

**□ Neglect of Individual**

**□ Medication Error**

**Describe in detail what happened and actions taken**

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| **Did anyone else witness the incident?** | Yes **□**  | No **□**  |

|  |
| --- |
| Name and contact information (phone & email) of the witness, if available: |
| **Other agencies notified:** |
|  CCL/DSS **□**  | DHS **□** | Parent/Guardian/Conservator **□** | Physician/Hospital **□** |
|  Police/Sheriff  **□**  | County Coroner **□**  | Other (specify) **□**  |

|  |
| --- |
| **Date reported to CCL/DHS:**  |

|  |
| --- |
| **Submitted by:** |
| Name: | Title: |
| Telephone #: | Email: |

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

|  |
| --- |
|  |