

**CRITICAL INCIDENT REPORT FORM:**

When an incident occurs, it is imperative that the information be forwarded to the appropriate staff as soon as possible because this information may be sent to authorities outside of the agency.

**Please complete this form entirely (please check all that apply):**

- Consumer Incident  
  Staff Incident  
  Staff/Consumer Incident  
  Executive Response Team Paged  
 Confidentiality Violation  
  Theft/Loss Property Damage  
  Universal Precautions Used  
 Wandering/Elopement  
  Abuse/Neglect  
  Aggression/Violence  
  Substances (legal/illegal)  
 Self-harm, Suicide  
  Seclusion/Restraint  
  Injury Incident

**Program Information:**  
 Office-Based  
 School  
 Home-Based  
 Community-Based  
 Other: \_\_\_\_\_

Incident Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 AM  
 PM

Program Type & Location of Incident:
Staff Name:
Consumer Name:
Visitor Name (Was Anyone Else Involved & their Name):

<b>Detailed Description of Incident: (Please report facts only and injury descriptions, if applicable).</b>

<b>Security Level:</b>
<input type="checkbox"/> No off-site medical care required, <input type="checkbox"/> First aid care administered on-site, <input type="checkbox"/> Medical care by a physician or nurse or follow up attention required, <input type="checkbox"/> Hospitalization or immediate off-site medical attention was required
Incident Reported to:
Date and Time Reported:
Incident Reported to Executive Clinical Director and/or Executive Staff:
Date and Time Reported:
Date Action/Resolution taken:
Abuse Hotline Contacted for Child? <input type="checkbox"/> Yes, <input type="checkbox"/> No.                   Abuse Hotline Contacted for Adult? <input type="checkbox"/> Yes, <input type="checkbox"/> No.
Referral Number: _____                   Name of Person Taking Referral for Report: _____
Person Reporting Incident Signature & Date: _____
Manager/Supervisor Signature & Date: _____
Reviewer Signature & Date: _____
Debriefing: Yes <input type="checkbox"/> , No <input type="checkbox"/> , N/A <input type="checkbox"/> with who, if Debriefing occurred: _____
Comments: _____