Maryland-Incident Reporting Form

Involved Individual(s)

Individual Name*	SSN

Discovery Date: _____ Time: _____ am/pm
Number of individuals present at the time of incident: _____ Number of staff present at the time of incident _____
Is the address where the incident occurred a DDA licensed site/service: □Yes □No

Agency Information
OHCQ Provider #: _____ OHCQ Site #: _____ Time of Report: _____ am/pm
Type of Program/Service provided for this individual: □Community Residential □ Day-Rehab □ OCYF □ Other □ Transportation □SRC □FISS □Medical day □ Vocational □ CSLA □ IFC
Is this a DDA licensed site?: □ Yes □ No

Fields required for interfacing
PCIS2 Site #:* _____
DDA Service Type:* □ BSS - Consulting □ CSLA □ Community learning services □ Day habilitation □ Employment discovery and customization □ Family support services □ IFC □ ISS □ Residential □ Resource coordination □ Self-directed/FMS service □ Supported employment □ Supported employment-contract
Incident Location:* □ Home □ Site □ Other _____
Briefly describe the circumstances of the incident:* _____
_____
_____
_____
Briefly describe status of individual at the time of report (Including any medical treatment needs if known):* _____
_____
_____
_____
_____
_____

Agency Contact Person
Name:* _____ Title:* _____
Address:* _____City: _____ State: _____
Zip Code: _____ Phone:* _____ Ext: _____ Fax:_____
E-mail:* _____
Type of Incident:* □ ER visit due to a severe injury □ Medication error requiring treatment □ Unplanned hospital admission □ Medication error requiring hospital admission □ Severe injury □ Neglect □ Leave w/o notification (individual in immediate danger) □ Theft of individual property (> $50) □ Leave w/o notification (absent > 4 hours) □ Police Dept. visit w/ report taken □ Fire Dept. visit □ Unauthorized/inappropriate use of restraints □ Chemical intervention □ Use of restraints that result in any type of injury □ Other_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)

For Hospital Admission / Emergency room visit
Name of Hospital: _____
What was the admitting diagnosis or rule out diagnosis?: _____
_____

For Abuse
This incident involves: ☐ Staff and individuals ☐ Two or more individuals
Indicate Primary Category: ☐ Physical abuse ☐ Use of aversive technique ☐ Inhumane treatment ☐ Seclusion ☐ Sexual abuse
☐ Psychological abuse ☐ Violation of an individual rights
Does the individual have a behavior plan(BP) which addresses unsubstantiated allegations of sexual or verbal abuse?:☐ Yes ☐ No
How will the safety of the individual be maintained during the investigation?: _____
_____

For Neglect
How will the safety of the individual be maintained during the investigation?: _____
_____
_____

For Injury
Does the individual have a history of pica?: ☐ Yes ☐ No
Does the individual have a behavior plan (BP) which addresses pica?: ☐ Yes ☐ No

For Death
Was death reported to a local law enforcement agency?: ☐ Yes ☐ No
Was hospice involved?: ☐ Yes ☐ No
Was EMT unit involved?: ☐ Yes ☐ No
If yes, identify unit: _____
Was medical examiner's office notified?: ☐Yes ☐ No

For Choking
Does the individual have a history of choking or on a specialized diet?: ☐ Yes ☐ No

For Medication Error
What medication/treatment was involved?: _____
_____
_____
Was the delegating nurse involved?: ☐ Yes ☐ No

For Restraint – Unauthorized / Inappropriate Use of Restrain
Does the individual have a behavior plan(BP) with restraints?: ☐ Yes ☐ No
Is the behavior targeted in the BP?: ☐ Yes ☐ No
Will the team be convened within 5 calendar days to review the situation and action taken?: ☐ Yes ☐ No
Is development of a behavior plan necessary?: ☐ Yes ☐ No
Was restraint utilized?: ☐ Yes ☐ No

For Restraint – Use of restraints that result in any type of injury
Does the individual have a behavior plan (BP) with restraints?: ☐ Yes ☐ No

For Unexpected or Risky Absent / (absent >= 4 hours)
Does the individual have any unsupervised time in the community? ☐Yes ☐ No
How vulnerable is the individual?: _____
_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
Note:- Required fields are marked with an asterisk (*)

What is IP required staffing ratio?: _____

Other / Suicide Attempt
Does the individual have a history or family history of suicidal ideation/attempts?: ☐ Yes ☐ No
If yes, how is it addressed, i.e. suicidal protocol, behavior plan?: _____
_____
_____

Other / Suicide Threat
Does the individual have a history of suicidal ideation?: ☐ Yes ☐ No
If yes, how is it addressed, i.e. suicidal protocol, behavior plan?: _____
_____
_____

Witness
Witness 1: _____ Witness One Interviewed: ☐ Yes ☐ No
Witness 2: _____ Witness Two Interviewed: ☐ Yes ☐ No
Witness 3: _____ Witness Three Interviewed: ☐ Yes ☐ No

Please list all staff on duty at time of incident:
1.
2.
3.

Notifications: Family
Does Individual have family?: ☐ Yes ☐ No Is family involved with individual?: ☐ Yes ☐ No
Notified Family's Name: _____ If Individual has family, when were they notified?: _____
Time: _____am / pm Has advocate, other than family been notified?: ☐ Yes ☐ No

Notifications: Law Enforcement
Was this incident reported to a law enforcement agency?: ☐ Yes ☐ No
If yes: Officer's name: _____
Jurisdiction:_____ Report # _____
Reason, if this incident was not reported to a law enforcement agency: _____
_____
_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
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