Form OPWDD 147

Was a related incident previously reported?: ☐ Yes ☐ No
Agency Incident Number: ______________ Master Incident Number: ________________ TABS ID (if applicable): ______________
Receives medication?: Yes No Unknown by person completing the form
Incident: ☐ Observed ☐ Discovered
Incident Date* ____________ Time: ________ am/pm Incident Occurred Date (if known) ____________ Time: _________ am/pm
Number of persons receiving services present at time of incident: _____ Number of employees present at time of incident: ______

Preliminary Classification (Select One)*

Reportable Incident - Abuse/Neglect:
☐ Physical Abuse ☐ Sexual Abuse ☐ Psychological Abuse ☐ Deliberate inappropriate use of restraints
☐ Use of aversive conditioning ☐ Obstruction of reports of reportable incidents
☐ Unlawful use or administration of a controlled substance ☐ Neglect

Reportable Incident - Significant Incidents:
☐ Conduct between individuals receiving services ☐ Seclusion ☐ Unauthorized use of time-out
☐ Medication Error with adverse effect ☐ Inappropriate use of restraints ☐ Mistreatment ☐ Missing person
☐ Choking, with known risk ☐ Self-abusive behavior with injury ☐ Choking with no known risk ☐ Unauthorized Absence
☐ Injury, with hospital admission ☐ Theft/Financial Exploitation ☐ Other significant incident

Serious Notable Occurrences: ☐ Death ☐ Sensitive Situation
Minor Notable Occurrences: ☐ Injury ☐ Theft/Financial Exploitation

Specific Location Where Incident Occurred*
☐ Living Room ☐ Bedroom ☐ Kitchen ☐ Bathroom ☐ Hallway ☐ Staircase ☐ Dining Room ☐ Program Room ☐ Recreation Area
☐ Off-Facility Property ☐ Unknown ☐ Vehicle ☐ Other ____
Brief Description of the Incident: ____
____
____

Notification to Justice Center:* ☐ YES ☐ N/A Date: ______________ Time: ___________ am/pm
JC Identifier: ______________________________ Reported By: ______________________________
Notification to Law Enforcement Officials:* ☐ YES ☐ N/A
Date Contacted ______________ Time: ____________ am/pm Law Enforcement Agency Name: ____________________
Permanent Residential Address and Phone Number (if applicable, of person receiving services) ____________________
____
____
Phone Number: ______________ Residence Type: ☐ SOIRA ☐ VOIRA ☐ SOICF ☐ VOICF ☐ FC ☐ DC ☐ CR ☐ Other ______
Reported By:* ____
Additional Steps Taken to Ensure the Individual's Safety ____
____
____
Additional Steps Given By: ______________________________ Date Additional Steps Added: ____________________

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

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

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