

REGIONAL CENTER OF ORANGE COUNTY

$\hfill \Box$ Special Incident Report $\hfill \Box$ Other Observations and Events FAX TO 714-796-0600

Consumer's Name: Sex: \square M		$\Box F$	Date of Report:				
Date of Birth: UCI Number:			Date/Time of In	cident:			
Check	Applicable: □Verbal □ Non-Verb	oal □Ambulatory □Non-Ambu	latory	y Location of Inci	dent:		
REQUIRED BY TITLE 17, §54327							
	☐ Sexual	cause or location) ehydration ety hazard giene shelter tation Psychological Physical restraint Chemical restraint endor has filed a Missing		Consumer was the victin A serious injury/acciden Dislocation Fracture Laceration requiring s Burns, bites, puncture treatment beyond first Medication reaction re Any medication error Unplanned or unschedul Respiratory illness Seizure-related activit Internal infection	t, including: sutures/staples/Der wounds or internatial equiring treatment (see below) ed hospitalization □ Diabet by □ Wounds	mabond al bleeding requiring beyond first aid due to: es-related activity l/Skin care ntary psychiatric	
	-		FOR MEDICATION ERRORS				
	itional incident types required for			Name of Medication	Dosage Se	chedule of Medication	
	Any occurrence/allegation of consumer abuse Event which may result in criminal charges or legal action Event which may result in denial of consumer's right(s) Event which appears to have a significant negative affect on consumer's health, safety, or well-being Poisonings Catastrophes Emergency treatment OTHER EVENTS/ Alleged violation of consumer's right(s) Voluntary psychiatric hospitalization Medical emergency Unauthorized absence Injury: From a seizure From a behavior episode From a peer		OBS	Diagnosis of communica Use of restrictive behavi Event which may result Arrest Health and safety issue Other sexual incident: Sexual harassment Behavior episode: Aggressive act to self Aggressive act to peer Aggressive act to community member	or intervention in criminal change Inap	propriate contact ressive act to staff ressive act to family or or	
		OTHER ACENCIES/IND	NVI		□ Othe	er	
OTHER AGENCIES/INDIVIDUALS INVOLVED Contact Name Telephone Report Number							
	Community Care Licensing (DSS) Licensing and Certification (DHS) Parent/Guardian/Conservator Physician/Hospital Police/Sheriff County Coroner Other Family Member/Vendor						
Investigating Agency Involved: Select Agency						Type	
		□APS □CPS □LTCO			Investigation Declined For Information On	ly	

DESCRIPTION OF INCIDENT (Title 17 requires a description of the alleged perpetrator, if applicable):							
DESCRIPTION OF INCIDENT (Title 17 requires a description of the alleged perpetrator, if applicable):							
(Attach a separate page for additional information if necessary)							
IMMEDIATE ACTION TAKEN BY SERVICE PROVIDER/VENDOR/OTHER:							
(Attach a separate page for additional information if necessary)							
MEDICAL TREATMENT NECESSARY: □Yes □No If Yes, Nature of Treatment:							
Administered At: Administered By:							
Follow-Up Treatment, If Any:							
PLAN TO PREVENT FURTHER OCCURRENCES:							
(Attach a separate page for additional information if necessary)							
COMMENTS (INCLUDE THE NAME/ADDRESS OF ANY WITNESS TO THE INCIDENT):							
(Attach a separate page for additional information if necessary)							
REPORT SUBMITTED BY							
Name (print):	Title:						
Vendor Name:	Vendor Number:						
DHS-L&C Lie. #:	DSS-CCL Lic. #:						
Telephone Number:	Signature/Date:						
receptione reunition.	Signature/Date.						