

**ALL fields MUST be filled in****INCIDENT REPORT FORM****FORM 1-8**

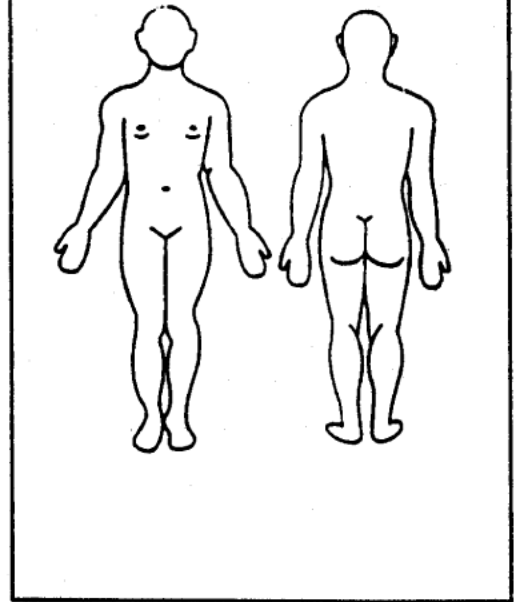
Utah DHS-DSPD

PERSON'S ID: _____		PERSON'S NAME:	
TODAY'S DATE: ____/____/____ MM DD YY		DATE INCIDENT STARTED: ____/____/____ MM DD YY	
YOUR NAME:		TIME INCIDENT STARTED: _____ AM/PM	
DATE INCIDENT ENDED: ____/____/____ MM DD YY		TIME INCIDENT ENDED: _____ AM/PM	
DATE SUPPORT COORDINATOR NOTIFIED: : ____/____/____ TIME: ____:____ AM/PM WHO?: _____			
DATE DSPD INCIDENT REPORT FILED: ____/____/____ TIME: ____:____ AM/PM			
YOUR TITLE:		YOUR PHONE NUMBER: ( )	
PROVIDER NAME:		PROVIDER SITE ADDRESS: City:	
NUMBER OF PEOPLE INVOLVED (INCLUDING PERSON IN SERVICES LISTED ABOVE):			
<b>NAMES and ROLES OF OTHERS INVOLVED or WITH PERTINENT INFORMATION, INCLUDING HEALTH CARE PROVIDERS, IF ANY: (DO NOT INCLUDE PERSON IN SERVICES LISTED ABOVE):</b>			
NAME:		ROLE:	
NAME:		ROLE:	
NAME:		ROLE:	
WHERE DID INCIDENT TAKE PLACE?		<input type="checkbox"/> Provider Site Listed Above <input type="checkbox"/> Day Program <input type="checkbox"/> School <input type="checkbox"/> Friend's Home <input type="checkbox"/> Relative's Home <input type="checkbox"/> Other Location (Describe Briefly):	
<b>ACTION TAKEN?</b>			
MEDICAL PROFESSIONAL NOTIFIED?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name:	Title:   Phone:
PERSON HOSPITALIZED?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital's Name:	Phone:
POLICE NOTIFIED?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ____/____/____	Time: _____ AM / PM
APS or CPS NOTIFIED?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ____/____/____	Time: _____ AM / PM
<b>TYPE OF INCIDENT?</b>			
<input type="checkbox"/> <b>INJURY</b>	Who Was Injured? <input type="checkbox"/> Person in Services <input type="checkbox"/> Another/Other Person(s) in Services <input type="checkbox"/> Staff <input type="checkbox"/> Other: Who caused the injury? <input type="checkbox"/> Person in Services <input type="checkbox"/> Another Person in Services <input type="checkbox"/> Staff <input type="checkbox"/> Other: Body part(s) injured: Severity/Treatment:		
<input type="checkbox"/> <b>ABUSE</b>	Who was abused? <input type="checkbox"/> Person in Services <input type="checkbox"/> Another Person in Services <input type="checkbox"/> Staff <input type="checkbox"/> Other: Who caused the abuse? <input type="checkbox"/> Person in Services <input type="checkbox"/> Another Person in Services <input type="checkbox"/> Staff <input type="checkbox"/> Other: Type of Abuse/Exploitation: <input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Emotional <input type="checkbox"/> Neglect <input type="checkbox"/> Financial Abuse was: <input type="checkbox"/> Observed <input type="checkbox"/> Suspected Severity/Treatment:		
<input type="checkbox"/> <b>CRIMINAL ACT</b>	Type of Act:		
<input type="checkbox"/> <b>DRUG/ALCOHOL</b>	<input type="checkbox"/> Incident <input type="checkbox"/> Overdose Drug/Alcohol involved: Severity/Treatment:		
<input type="checkbox"/> <b>Med Error (Resulting in Medical Procedure)</b>	Medication(s) involved: Severity/Treatment:		
<input type="checkbox"/> <b>Missing Person</b>	Date Last Seen: ____/____/____   Time Last Seen: _____ AM / PM Where last seen? Date Found/Returned: ____/____/____   Time Found/Returned: _____ AM / PM		
<input type="checkbox"/> <b>SEIZURE<sup>1</sup></b>	Duration: Brief Description of Event:		
<input type="checkbox"/> <b>Intrusive Behavioral Intervention<sup>2</sup></b>	Cause: <input type="checkbox"/> Aggression <input type="checkbox"/> Self-Injurious Behavior (SIB) <input type="checkbox"/> Other: Intervention used: _____   Duration: ____:____ (HH:mm)		
<input type="checkbox"/> <b>Property Destruction</b>	Item(s) Destroyed: _____   Cost to repair/replace? \$ _____ Owner(s) of Item(s) destroyed:		
<input type="checkbox"/> <b>OTHER INCIDENT</b>	Please provide brief description:		



**Describe Incident in Detail;  
Include How Each Person Was Involved:**

**Please mark the body parts injured**



**Provider Signature:**

**Title:**

**Support Coordinator Recommendation / Follow-Up:**

*(Attach APS or CPS Referral Sheet and Final Outcome of Investigation; Indicate with whom you consulted about this incident)*

**Support Coordinator Signature:**

**Date Notified:**

**Today's Date:**