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	TIME INCIDENT STARTED: ________ AM/PM
YOUR NAME:	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):		

NAMES and ROLES OF OTHERS INVOLVED or WITH PERTINENT INFORMATION, INCLUDING HEALTH CARE PROVIDERS, IF ANY:
(DO NOT INCLUDE PERSON IN SERVICES LISTED ABOVE):

NAME:	ROLE:
NAME:	ROLE:
NAME:	ROLE:
WHERE DID INCIDENT TAKE PLACE?	☐ Provider Site Listed Above ☐ Day Program ☐ School ☐ Friend's Home ☐ Relative's Home ☐ Other Location (Describe Briefly):

ACTION TAKEN?

MEDICAL PROFESSIONAL NOTIFIED?	☐ Yes ☐ No	Name: Title: Phone:
PERSON HOSPITALIZED?	☐ Yes ☐ No	Hospital's Name: Phone:
POLICE NOTIFIED?	☐ Yes ☐ No	Date: ____/____/_____ Time:_____________ AM / PM
APS or CPS NOTIFIED?	☐ Yes ☐ No	Date: ____/____/____ Time: _____________AM / PM

TYPE OF INCIDENT?

☐ **INJURY**	Who Was Injured? ☐ Person in Services ☐ Another/Other Person(s) in Services ☐ Staff ☐ Other: Who caused the injury? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other: Body part(s) injured: Severity/Treatment:
☐ **ABUSE**	Who was abused? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other: Who caused the abuse? ☐ Person in Services ☐ Another Person in Services ☐ Staff ☐ Other: Type of Abuse/Exploitation: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Financial Abuse was: ☐ Observed ☐ Suspected Severity/Treatment:
☐ **CRIMINAL ACT**	Type of Act:
☐ **DRUG/ALCOHOL**	☐ Incident ☐ Overdose Drug/Alcohol involved: Severity/Treatment:
☐ **Med Error** *(Resulting in Medical Procedure)*	Medication(s) involved: Severity/Treatment:
☐ **Missing Person**	Date Last Seen: ____/____/_____ Time Last Seen:_____________ AM / PM Where last seen? Date Found/Returned: ____/____/_____ Time Found/Returned:_____________ AM / PM
☐ **SEIZURE**[1]	Duration: Brief Description of Event:
☐ **Intrusive Behavioral Intervention**[2]	Cause: ☐ Aggression ☐ Self-Injurious Behavior (SIB) ☐ Other: Intervention used: ___________________________ Duration:____:____(HH:mm)
☐ **Property Destruction**	Item(s) Destroyed: Cost to repair/replace? $__________.____ Owner(s) of Item(s) destroyed:
☐ **OTHER INCIDENT**	Please provide brief description:

INCIDENT REPORT FORM

FORM 1-8

[1]If person has a diagnosis of Seizure Disorder, a monthly summary of seizures may be used instead of this form.
[2] Must be completed for: a) ANY intrusive intervention not specified in a current behavioral plan; or, b) Any intrusive intervention involving restraint or the use of a time-out room even if specified in current behavioral plan. An Emergency Behavioral Intervention Review must be completed below when an emergency behavioral intervention occurs.

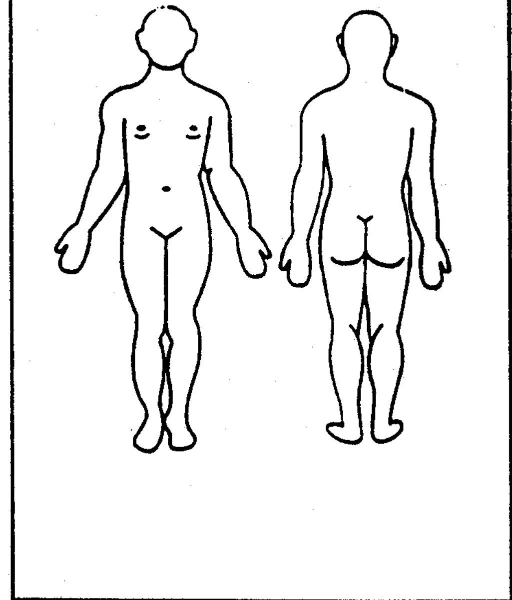
Emergency Behavioral Intervention Review:

(i) The circumstances leading up to and following the problem:

(ii) If the Emergency Behavior Intervention was justified

(iii) Recommendations for how to prevent future occurrences, if applicable.

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



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: