**SPECIAL INCIDENT REPORT FOR ALL VENDORS**

***TO BE E-MAILED OR FAXED TO SAN ANDREAS REGIONAL CENTER***

**(Within 24 hours of the incident)**

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| **Consumer’s Name: UCI #:** | **Date of Written Report:** |
| **Consumer’s Address:** | **Date of Birth:**  **Sex: \_\_\_\_\_\_Male \_\_\_\_\_Female** |
| **Vendor or Agency Name: Vendor #:** | **Service Coordinator:** |
| **Conservator/Guardian name (if applicable):** | **CCL Facility Number:** |
| **Name of person reporting:** | **Position at agency:** |

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| **TYPE OF INCIDENT**  **(Check all that apply*) Double-click in the box, then select “checked” in “Default Value”*** | |
| **Injuries Requiring Treatment Beyond First Aide**  **Burns that require medical treatment beyond first aide**  **Medication reactions**  **Bites that break the skin/ require treatment**  **Internal bleeding**  **Puncture wounds requiring treatment**  **Medical Need/Accident/Other:**  **Fractures**  **Injury-Accident**  **Lacerations requiring sutures/ staples/glue**  **Medication Errors**  **Disease Outbreak**  **Injury-Unknown origin**  **Injury from seizure**  **Injury from another consumer**  **Injury from behavior episode**  **Choking**  **Other**  **Condition Requiring Medical Intervention**  **Drug/Alcohol Abuse**  **Emergency Room Visit**  **Seizures**  **Theft by a Consumer**  **Community Safety**  **Law Enforcement Involvement**  **EPS-Psych Emergency Team-No Hospital Admission**  **Pregnancy**  **Planned Hospitalization**  **Voluntary Psych Admission**  **Suspected Abuse/Exploitation**  **Alleged Consumer Financial Abuse**  **Alleged Physical Abuse**  **Alleged Sexual Abuse**  **Alleged Emotional/Mental Abuse**  **Alleged Physical/Chemical Restraint**  **Alleged Abuse-Other**  **Alleged Violation Of Rights** | **Suspected Neglect**  **Failure to Provision of Food/ Clothing/ Shelter**  **Failure to Assist in Personal Hygiene**  **Failure to Prevent Dehydration**  **Failure to Protect Health/Safety Hazards**  **Failure to Provide Medical Care**  **Failure to Provide Care Elder/Adult**  **Failure to Prevent Malnutrition**  **Alleged Neglect-Other**  **Unauthorized Absence**  **Missing Person Law Notified**  **Unauthorized Absence-Law Not Notified**    **Unplanned Hospitalizations**  **Involuntary psychiatric admission**  **Nutritional deficiencies**  **Cardiac**  **Diabetes**  **Internal infection**  **Respiratory illness**  **Seizures**  **Wound/skin care**  **Other**  **Victim of Crime**  **Aggravated assault**  **Burglary**  **Larceny**  **Personal Robbery**  **Rape or Attempted Rape**  **Aggressive Acts**  **Aggressive act to another consumer**  **Aggressive act to family/visitor**  **Aggressive act to self**  **Aggressive act to staff**  **Severe Verbal Threats**  **Suicide Attempt**  **Suicide Threat**  **Other Sexual Incident**  **Property Damage**  **Fire Setting**  **Aggressive Act Involving a Weapon**    **Death** |
| **Incident date**  Definite  Approximate | **Time of incident**  Definite  Approximate |
| **Date incident reported to RC** | **Medical Care/Treatment Required.**  Yes  No |
| **Relationship of alleged perpetrator to consumer**  Self  Another Consumer  Vendor or Employee of Vendor  Non-Vendor or Employee of Non-Vendor | Relative/Family Member  Individual known to consumer (Not a provider or another consumer)  Unknown  Not applicable |

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| **Incident location – *where the incident happened***  **(Check only one)** | | | | |
| Day program  Consumer’s residence  Community setting  Home of family  In transit  Day care/ Intervention program | | Acute hospital–Emergency Room  Acute hospital–not ER  Out of home respite  Sub-acute or pediatric sub-acute  SNF  Psychiatric treatment center | | Job Site  Hospice  Jail or related setting  Public school  Rehabilitation facility  Other |
| **Person/Agency responsible for consumer at time of incident** | | | | |
| Vendor Residential  Parent/Family Day Program  Other | Name:  Address:  City/Zip:  Telephone: Vendor # | | | |
| **Other agencies notified by person/agency making this report** | | | | |
| Community Care Licensing  Child Protective Services  Parent/Guardian/Conservator  Police/Law Enforcement  Coroner | | | DHCS/DPH Licensing & Certification  Adult Protective Services  Long-Term Care Ombudsman  Other Specify  Day Program  □ | |
| **Description of incident** (Who, what, when, where, details)**:** | | | | |
| **Attending Physician’s name, findings, and treatment:** | | | | |
| **Specific preventative action taken or planned** (procedures/plans taken to prevent incident from happening again)**:** | | | | |
| **Disposition:** | | | | |

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| **Complete Only if Incident Type is Death** | |
| **Describe the circumstances of the consumer’s death/nature of medical treatment and where administered** | |
| **Other comments or information regarding death ( Please include all psycho-social information)** | |
| **Type of Death**  ***Disease Related***  ***Unknown*** | ***Non-Disease Related***  Homicide  Suicide  Accident  Alleged Abuse/Neglect  Suspected Substance Abuse  Catastrophic Event (Fire, Flood)  Other (specify) |

Revised 08.07.13 Please submit SIR As WORD document To SARC SIR E-Mail Address.

See instructions on [www.sarc.org](http://www.sarc.org)