**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 |
| In**cident 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 11.23.20 Please submit SIR As WORD document To SARC SIR E-Mail Address.

 San Jose Special Incident Report sirsanjose@sarc.org

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