Date faxed (emailed) to SSA or SSA Office: _____

Unusual Incident Report Form

(PLEASE PRINT)

1. This report must be completed by reporting personnel before end of work day (unless after hours, then next business day.)

Individual's name: _____DOB: _____

Date of incident: _____ Time of Incident:_____ AM/PM

Location of Incident:_____

Reporter(s):_____

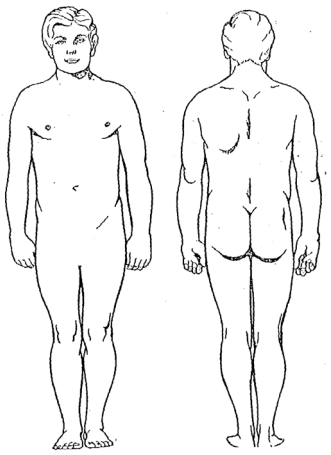
Date reporter discovered incident:_____ Time:_____AM/PM

Witnesses: _____

PPI Name: _____Relationship to individual? _____
(Primary Person Involved)

Individual assessed for injury? YES NO N/A (TO BE FILLED OUT BY PROGRAM NURSE OR NURSE DELEGATE)

By whom? _____ Date/Time:_____AM/PM



NATURE OF INJURY (INDICATE TYPE AND LOCATION)

A. None	I. Head injury
B. Abrasion/bruise/contusion	J. Laceration/Scratch
C. Airway obstruction	K. Puncture
D. Bite	L. Skin irritation
E. Burn	M. Sprains/strain/dislocation
F. Exposure to cold/heat	N. Tooth injury
G. Eye injury	O. Unable to determine
H. Fracture	P. Other:_____

TREATMENT GIVEN? YES NO N/A DESCRIBE TREATMENT:_____

_____

_____

_____

_____

Does the individual have a Behavior Support Plan? Yes No Does the plan include a physical restraint? Yes No
Was restraint implemented? Yes No (Record details in description of incident):

Describe what was happening just before the actual incident :_____

_____

_____

_____

_____

_____

Description of Incident (during, what happened specifically, length of time (attach additional sheets if necessary): _____

_____

_____

_____

_____

_____

_____

Immediate action taken to ensure health and safety: _____

_____

_____

_____

_____

Staff Signature:_____Date/Time_____

Report given to (staff making notification):_____Date:_____

Law Enforcement notified? Yes No N/A Officer's name:_____

By whom? _____ Date/time:_____

Children's Services notified? Yes No N/A Caseworker's name: _____

By whom? _____Date/time:_____

Other Notifications:	Name:	By Whom:	Date:	Time:	Method:
Guardian	_____	_____	_____	_____	_____
Parent/Advocate	_____	_____	_____	_____	_____
Provider	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(UI Must Route to County Board within 1 – 3 days of Incident)

Preventative Measures (recommendations from provider):_____

_____

_____

_____

Signature of Person Completing report (staff from routing):_____Date:_____

SSA Follow-up:

SSA Signature: **Date:**

Revised: 12/9/13

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