SPECIAL INCIDENT REPORT FOR ALL VENDORS

TO BE E-MAILED OR FAXED TO SAN ANDREAS REGIONAL CENTER
(Within 24 hours of the incident)

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:**

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

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 ☐ Parent/Family ☐ Other	☐ Residential ☐ Day Program	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:

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	*Non-Disease Related*	
☐ ***Disease Related***	☐ Homicide	☐ Suicide
☐ ***Unknown***	☐ 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**