

**State of Maryland, Department of Health and Mental Hygiene
Developmental Disabilities Administration
Incident Reporting Form**

Appendix 4

A) Was more than one individual involved in this incident? Y N. If Yes, submit a separate Appendix 4 for each individual. In order to link all individuals in one incident, please provide the name and Social Security number for each additional individual involved in the space provided below. (If more than 3 please attach additional page)

1) _____ 2) _____ 3) _____

I) Individual #1

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address:	DOB: / /
City:	State:
Individual's social security number: / /	Zip:
Date and time incident occurred: / / at : <input type="checkbox"/> AM <input type="checkbox"/> PM (Check One)	
If different, when was incident discovered: / / at : <input type="checkbox"/> AM <input type="checkbox"/> PM (Check One)	
# of individuals present at the time of incident:	# of staff present at time of incident:
Address where incident occurred, if different from individual's address:	
Is the address where incident occurred a DDA licensed site/service? <input type="checkbox"/> Y <input type="checkbox"/> N	

II) Agency Information Name:

OHCQ Provider #:	Date Of Report: / /
OHCQ Site #:	Time of Report: : <input type="checkbox"/> AM <input type="checkbox"/> PM (Check One)
What type of program/service is provided for this individual? <input type="checkbox"/> Community Residential <input type="checkbox"/> Day - Rehab <input type="checkbox"/> OCYF	
<input type="checkbox"/> Other <input type="checkbox"/> Transportation <input type="checkbox"/> SRC <input type="checkbox"/> FISS <input type="checkbox"/> Medical day <input type="checkbox"/> Vocational <input type="checkbox"/> CSLA <input type="checkbox"/> IFC	
Is this a DDA licensed site? <input type="checkbox"/> Y <input type="checkbox"/> N	

III) Agency Contact Person

Name:	Title/Relationship:
Address:	Phone #: () - ext:
City: St: Zip: Fax #: () -	
Email Address: @	

IV) Type of Incident: Check only the primary incident category that indicates the suspected or known cause of the incident: (See section V below if selecting abuse)

<input type="checkbox"/> ER visit due to a severe injury	<input type="checkbox"/> Medication error requiring treatment
<input type="checkbox"/> Unplanned hospital admission	<input type="checkbox"/> Medication error requiring hospital admission
Name of Hospital:	<input type="checkbox"/> Severe injury
<input type="checkbox"/> Neglect	<input type="checkbox"/> Leave w/o notification (individual in immediate danger)
<input type="checkbox"/> Theft of individual's property (> \$50)	<input type="checkbox"/> Leave w/o notification (absent > 4 hours)
<input type="checkbox"/> Police Dept. visit w/ report taken	<input type="checkbox"/> Fire Dept. visit
<input type="checkbox"/> Unauthorized/inappropriate use of restraints	<input type="checkbox"/> Chemical intervention
<input type="checkbox"/> Use of restraints that result in any type of injury	
<input type="checkbox"/> Other-explain:	

V) For abuse: This incident involves: Staff and individuals OR Two or more individuals

Indicate Primary Category:

<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Use of aversive technique	<input type="checkbox"/> Inhumane treatment	<input type="checkbox"/> Seclusion
<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Psychological abuse	<input type="checkbox"/> Violation of an individual's rights	

VI) In cases of Death: Location of death:

DOD: / /	Was the death a result of unusual, suspicious or unnatural causes? <input type="checkbox"/> Y <input type="checkbox"/> N
Was death reported to a local law enforcement agency? <input type="checkbox"/> Y <input type="checkbox"/> N	Was hospice involved? <input type="checkbox"/> Y <input type="checkbox"/> N
Has an autopsy been requested? <input type="checkbox"/> Y <input type="checkbox"/> N	Was death anticipated? <input type="checkbox"/> Y <input type="checkbox"/> N
Was medical examiner's office notified? <input type="checkbox"/> Y <input type="checkbox"/> N	
Was EMT unit involved? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, identify unit:

OHCQ USE ONLY

Received date: / /	Time :	OHCQ investigation #:
Date incident # given to agency: / /	Triage staff Initials:	

Rev: 10/2007

State of Maryland, Department of Health and Mental Hygiene
Developmental Disabilities Administration
Incident Reporting Form

Appendix 4 – Page 2

DDA Incident Reporting Form #

VII) Briefly describe the circumstances of the incident: (Be certain to include effects on person involved and any other pertinent information that will assist in assessment)

VIII) Briefly describe status of individual at the time of report: (Including any medical treatment needs if known)

Rev: 10/2007

Effective Date: October 1, 2007

State of Maryland, Department of Health and Mental Hygiene
 Developmental Disabilities Administration
 Incident Reporting Form

Appendix 4 – Page 3

IX) Witnesses to the incident:

Name (Last, First)	Address	Phone #
		() -
		() -
		() -

X) Please list all staff on duty at time of incident: (Use additional pages if necessary)

Name	Job Title

XI) Notifications: Please list persons notified: (Use additional pages if necessary)

Family

Does individual have family? Y N Is family involved with individual? Y N

If individual has family, when were they notified? / / at AM PM (check One)

Has advocate, other than family been notified? Y N

Law Enforcement

Was this incident reported to a law enforcement agency? Y N

If yes: Officer's name: _____ Jurisdiction: _____ Report #: _____

Name	Relationship/Agency	Date
	Resource Coordinator	/ /
	DDA Regional Office	/ /
	OHCQ	/ /
	*MDLC	/ /
	**CPS/APS	/ /
	Other	/ /

* The following must be reported to MDLC: All Deaths, Hospital Visits, Medication Errors, Reportable Restraint Use, Reportable injury and any incident that may be the result of abuse or neglect.

**Incidents must be reported to CPS/APS per: Irregular situations - section 1A and Appendix 2A – Sections 6 & 7 of Other Agency/SRC requirements

XII) Agency/SRC staff person completing this form: (Please print)

Rev: 10/2007

State of Maryland, Department of Health and Mental Hygiene
Developmental Disabilities Administration
Incident Reporting Form

Appendix 4 - Page

Rev: 10/2007

Effective Date: October 1, 2007