CONFIDENTIAL CLIENT INFORMATION
W&I CODE, SECTION 4524

# San Diego Regional Center
## SPECIAL INCIDENT REPORT

**(For SDRC Vendors and Long Term Care Facilities)**

***(Retain copy of this report in consumer's file, Notify CCL/SDRC within 24 hours of occurrence of incident and submit to SDRC written report within 48 hours and to CCL within 7 days of occurrence)***

**TO**:_____, SDRC Service Coordinator

## SECTION I

Consumer's Name: _____ UCI#:_____
Date of Birth: _____ Age:_____ Gender: M___ F___
Date of Incident: _____ Time of Incident: _____
Date Reported to SDRC/Lic. Agency: _____ Date of Admission to Facility:_____
Location of Incident:

[ ] Home of Family/Consumer [ ] Consumer's Residence [ ] Day program [ ] In-Patient hospice [ ] Job site
[ ] In Transit (Vehicle) [ ] ER of Acute Hospital [ ] Community [ ] Acute Hospital, not ER [ ] School
[ ] Other (Please specify)_____

Please indicate below the name of the place where the incident occurred. (Ex: Name of transportation, name of job site, name of foster home):
_____

## SECTION II

**TYPE OF SPECIAL INCIDENT**

[ ] **Death - Regardless of cause or location**
[ ] **Missing Person – law enforcement notified**
Consumer a victim of crime:
[ ] **Burglary**
[ ] **Larceny**
[ ] **Robbery**
[ ] **Rape or attempt to rape**
[ ] **Aggravated assault**
Reasonably Suspected Abuse or Exploitation:
[ ] **Physical abuse**
[ ] **Fiduciary abuse**
[ ] **Sexual abuse**
[ ] **Mental/emotional abuse**
[ ] **Physical/chemical restraint**
Reasonably suspected neglect including failure to:
[ ] **Provide medical care**
[ ] **Prevent malnutrition**
[ ] **Protect from health and safety hazard**
[ ] **Assist in personal hygiene/provide food, clothing and shelter**
[ ] **Exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of a elder or a dependent adult.**

A serious injury or accident requiring medical treatment including:
[ ] **Fracture**
[ ] **Dislocation**
[ ] **Laceration requiring sutures/stitches** /staples/glue
[ ] **Puncture wound requiring medical attention beyond first-aid**
[ ] **Bites that break the skin requiring medical attention beyond first-aid**
[ ] **Burns requiring medical attention beyond first-aid**
[ ] **Internal bleeding requiring medical attention beyond first-aid**
[ ] **Medication reaction requiring medical attention beyond first-aid**
[ ] **Any medication error:**
**Name of medication(s)/dose/frequency**:_____
_____
_____
Unplanned/unscheduled hospitalization
[ ] **Respiratory illness** [ ] **Seizure related**
[ ] **Diabetes related** [ ] **Cardiac related**
[ ] **Internal infection** [ ] **Wound/skin care**
[ ] **Nutritional deficiency/dehydration**
[ ] **Involuntary psychiatric hospitalization**

Other incidents:
[ ] Suicide attempt
[ ] Diagnosis of communicable disease
[ ] Prone/supine containment
[ ] Violation of consumer rights
[ ] Aggressive act to self
[ ] Aggressive act to another consumer
[ ] Aggressive act to staff/family/visitors
[ ] Medical emergency/ER visit/not hospitalized
[ ] Property damage
[ ] Fire/explosion occurring in premises
[ ] Poisoning
[ ] Epidemic outbreak
[ ] Serious illness
[ ] Infestation of parasites/vectors
[ ] Injury accident
[ ] Pregnancy
[ ] Others (specify)_____
_____
_____

## SECTION III — Description of Special Incident/Death

***(Include conditions prior to incident/death, any consumer/staff involved)***

(Please attach a separate page to capture all of the information. If hand writing, please make sure it is legible.)

_____
_____
_____
_____
_____
_____

## SECTION III (continued)

**Description of Alleged Perpetrator, if applicable**: [ ] Not Applicable

Name:_____ **Relationship to Consumer**: [ ] Relative/family member

Height:_____ [ ] Another consumer [ ] Non-vendor/employee of non-vendor

Weight:_____ [ ] Self [ ] Other individual known to consumer

Age:_____ [ ] Unknown [ ] Vendor/employee of vendor

**Medical Treatment Provided to Consumer**? [ ] Yes [ ] No

**If Yes, where**?_____ [ ] Hospital admission [ ] ER [ ] Urgent Care [ ] On Site

Nature of injury/treatment_____

Follow-up treatment, if any:_____

Name and phone number of physician:_____

Name of mortician/funeral home (if applicable):_____

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## SECTION IV

**Action(s) taken by vendor in response to Special Incident**:_____

[ ] Staff training [ ] Policies revised [ ] Staff terminated

[ ] Referral to Clinical Services [ ] Planning Team meeting [ ] Staff suspended

[ ] Reported to other agencies [ ] Review/Revise behavior plan

[ ] Other (please specify)_____

**Plan to prevent further occurrence/anticipated result**:_____

_____

_____

**Comments**:_____

_____

**Name/Address/Phone # of any witness to the incident (if any)**:_____

_____

**Consumer is:** ☐ **Verbal** ☐ **Non-Verbal** ☐ **Ambulatory** ☐ **Non-Ambulatory**

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## SECTION V

**Parties/Agencies Notified:**

| Party/Agency | Name of Contact | Phone # | Date Notified |
|---|---|---|---|
| [ ] APS/CPS | | | |
| [ ] Law Enforcement | | | |
| [ ] LTC Ombudsman | | | |
| [ ] CCL/HDL | | | |
| [ ] Coroner | | | |
| [ ] Parent/Conservator/Guardian | | | |
| [ ] Care Provider/Residence | | | |
| [ ] Others (please specify) | | | |

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## SECTION VI

**Report Written By**:

Name:_____ Facility/Vendor Name:_____

Title & Signature:_____ Vendor Address:_____

_____

**Reviewed By**:

Name:_____ Vendor Number:_____

Title & Signature:_____ Phone Number:_____

Date:_____ DHS/CCL License #:_____

**PLEASE FAX TO SDRC SERVICE COORDINATOR**

**SECTION VII**

## FOR SDRC USE ONLY

**Action(s) taken/planned by SDRC**:

[ ] Increased case management
[ ] Plan of corrective action
[ ] Training and technical assistance
[ ] Participate in discharge planning
[ ] Other_____

[ ] Increased clinical service
[ ] Consumer relocated
[ ] Planning Team meeting

[ ] Additional support and services
[ ] Additional services/supports declined
[ ] Sanctions imposed

**Notification of agencies confirmed/verified**: ☐ **Yes** ☐ **No**

**Comments**:

_____

_____

**SERVICE COORDINATOR**:_____ Signature:_____

Unit #:_____ Phone #:_____

Date SIR Received:_____ Date Sent to SIR Coordinator:_____

***Service Coordinator to EMAIL both sides of this form to SIR Coordinator at sirs@sdrc.org if Special Incident reportable to DDS. If unable to EMAIL please fax to*** **858-496-4327**