

Page ___1_ of _____ NAME OF CONTRACTED PROVIDER OR PROVIDER AGENCY: _____

*Licking County Board of DD
Unusual Incident Reporting (UIR)Form*

PLEASE PRINT LEGIBLY!

NAME OF INDIVIDUAL SERVED: _____ Today's Date: _____

Adult Child

PRINTED NAME OF PERSON COMPLETING UIR: _____ **Title:** _____

LOCATION/SITE OF INCIDENT: _____ **INCIDENT DATE:** _____ **TIME:** _____

FULL NAMES ONLY of staff and others who witnessed the incident. (INITIALS ONLY, if witness is served by LCBDD.)

Describe what was happening just before the actual incident:

Describe the actual incident (What happened, how did it happen, staff interventions, if any; use clear language and be specific):

Describe any injuries (what and to whom) and/or property damage: _____

Injury/Body Marks Attachment Completed? Yes No Accident/Illness Report Completed? Yes No
(One of boxes need marked)

Recommended Preventative Measures to avoid future similar incidents: Counseling Increased Monitoring

Health/Safety Training Evaluate BSP BSP effective, Continue to implement Special Meeting Scheduled

Other: _____

Comments regarding preventative measures _____

Incident was reported to (supervisor or designee): _____ **Time Reported** _____

Signature of person completing report form: _____

Supervisory/Agency Review

Names of Notifications Made:

Parent/Guardian	Date	Time	Method	Notified by
Service Coordinator	Date	Time	Method	Notified by
MUI Investigator	Date	Time	Method	Notified by
Children Services/Law Enforcement	Date	Time	Method	Notified by
Other (<i>Licco, Res. Provider, Transportation, etc.</i>)	Date	Time	Method	Notified by

Type of Incident: (*Please choose only one that best applies.*)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Alleged Abuse/Neglect | <input type="checkbox"/> Death | <input type="checkbox"/> Suicide Threat/Attempt | <input type="checkbox"/> Medication Error |
| <input type="checkbox"/> Law Enforcement Involvement | <input type="checkbox"/> Missing Money/Property | <input type="checkbox"/> Missing Person | <input type="checkbox"/> Behavioral Incident |
| <input type="checkbox"/> Alleged Rights Violation | <input type="checkbox"/> Injury of Known Origin | <input type="checkbox"/> Injury of Unknown Origin | <input type="checkbox"/> Fire/Damage to Home |
| <input type="checkbox"/> Fall | <input type="checkbox"/> Hospital Admission | <input type="checkbox"/> Emergency Medical/ER | <input type="checkbox"/> Peer to Peer |

OTHER (please describe): _____

PRIMARY PERSON INVOLVED (PPI) _____

RELATIONSHIP OF PPI TO INDIVIDUAL: _____

Results/Recommendations of Incident Review, Including THE IMMEDIATE ACTION TAKEN TO ENSURE THE INDIVIDUAL'S HEALTH & SAFETY (must comment if signed):

Signature/Title

Date/Time

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