ALC/CLA/PCH Incident Reporting Form

Facility: _____ County: _____
Phone: _____ Fax: _____ Email: _____
Administrator or Site Manager: _____

Type of Incident (check all that apply):

☐ **Abuse:** ☐ Physical ☐ Verbal ☐ Sexual ☐ Mental ☐ Resident to resident ☐ Staff to resident
☐ **Death:** ☐ Unexpected ☐ Waiver request pending ☐ Hospice provided ☐ 911 called (Time _____)
☐ PCH initiated CPR by (Staff Name: _____)
☐ **Serious Injury:** ☐ Resulted in death ☐ Hospital admission ☐ ER visit ☐ MD visit
☐ **External Disaster:** ☐ Fire ☐ Flood ☐ Damage to physical plant ☐ Residents relocated
☐ **Missing Resident:** ☐ Police notified (Date_____ Time_____)
☐ Resident has memory impairment
☐ **Other:** ☐ Neglect ☐ Exploitation ☐ Owner/staff acquires criminal record ☐ Insurance/will
☐ Other (specify) _____

Resident Name(s): _____

Date of Incident: _____ Time of Incident: _____
Details of Incident: (attach a page for additional details, if needed)

Notifications	Date	Time (AM or PM)	Name
Family/guardian/ responsible party			
Physician			
Police			
Other (specify)			

Alleged Perpetrator Name: _____
Relationship to Resident: _____
Current Address: _____ Phone: _____
City: _____ State: _____ Zip _____

Witness Names	Address	Phone Number	Relationship to Resident

Immediate correction or steps taken to prevent further incidents:

Reporter: _____ Title: _____
Signature: _____ Date of Report: _____ Time of Report: _____