

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: _____