1-800-562-6078
INCIDENT DESCRIPTION WORKSHEET

Please answer the following questions to the best of your ability. Specific details will help in providing a more complete report.
Use the blank column on the right to note your responses. Use of this worksheet is optional.
Press 1 to listen to your recorded answer; press 1, 1 to forward to the next question

GENERAL INFORMATION	
Reporter's first and last name (spell)/job title:	
Facility name/type of facility/address/phone:	
Alleged-**All** residents/person involved: spell first/last name with middle initial/gender/DOB/ADSA ID (if known):	
Diagnosis:	
Mental Status: (CHOOSE FROM: Independent, Modified Independence, Moderately Impaired OR Severely Impaired)	
Ambulatory Status: (CHOOSE FROM: Independent, Supervision, Limited Assistance, Extensive Assistance OR Total Dependence)	
Transfer Status: (CHOOSE FROM: Independent, Supervision, Limited Assistance, Extensive Assistance OR Total Dependence)	
Date and time of incident:	
Date and time incident first reported to supervisors:	
MD/Responsible Party Notified:	
Sexual:	
Describe incident/ allegation/ circumstances:/location:	
Witnesses:	
FALLS	
Fall preventions at time of incident:	
Fall result in injury/Describe: size/shape/color/location (where applicable). Similar injuries in last three months(?):	
Describe Injuries: size/shape/color/location (if applicable):	
Treatment/additional care (if applicable):	
Action taken to prevent recurrences:	
Pattern/Isolated:	
STAFF	
Staff involved:	
Measures to notify staff of care plan changes:	
Care plan followed (at time of incident):	
Care plan changes:	
Alleged Perp /Title/license/certification/registered:	
DOB/Hire/SSN	
Previous warnings/incidents (conduct with residents):	
Action Taken (include dates if applicable):	
Action taken to prevent recurrences:	
Additional agencies/LLE/Fire Dept/Medical Examiner/case number:	
EXPLOITATION	
Describe exploitation/dollar amount/location/victim's access to secure valuables:	
Victim reimbursed/if not why:	
MEDICATION ERROR	
Describe Error/discovered/including meds/dosages:	
Negative outcome to resident(s):	
Treatment/additional care (if applicable):	
Other pertinent information not previously stated	