|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date Reported to the DBHR: | | | | Date of Incident: | | | | Time of Incident:       (*24 hour)* | | | | | | Location of incident: | | | | |
| Reporting Site:  Provider Agency: | | | | | | | | | Name of Reporter: | | | | | | Phone/Email:       / | | | |
| Brief description of the incident: | | | | | | | | | | | | | | | | | | |
| UNSUBSTANTIATED | | | | | SUBSTANTIATED | | | | | | | | UNDER INVESTIGATION/UNDETERMINED | | | | | |
| POTENTIAL FOR MEDIA COVERAGE? | | | | | | | | | | | PROPERTY DAMAGE? | | | | | | | |
| **TYPE OF INCIDENT**  *Instructions: Please click on the appropriate category for drop down menu where indicated by an asterisk* | | | | | | | | | | | | | | | | | | |
| \*    \* | | | | | | | | | | | \* | | | | | | | |
| **PATIENT(1) INFORMATION** | | | | | | | | | | | **PATIENT(2) INFORMATION** | | | | | | | |
| Patient Identifier: | | Name: Last, First | | | | | | | | | Patient Identifier: | | | | | | | Name: Last, First |
| **PATIENT(3) INFORMATION** | | | | | | | | | | | **PATIENT(4) INFORMATION** | | | | | | | |
| Patient Identifier: | | Name: Last, First | | | | | | | | | Patient Identifier: | | | | | | | Name: Last, First |
| **STAFF (1) INFORMATION** | | | | | | **STAFF (2) INFORMATION** | | | | | | | | | | **STAFF (3) INFORMATION** | | |
| Name: Last, First | | | | | | Name: Last, First | | | | | | | | | | Name: Last, First | | |
| **VISITOR/OTHER INFORMATION** | | | | | | | | | | | | | | | | | | |
| Name: Last, First | Relationship: | | | | | | | | | | Other Pertinent Information Related to the Visitor: | | | | | | | |
| **OTHER AGENCY/FACILITIES NOTIFIED/INVOLVED** | | | | | | | | | | | | | | | | | | |
| Law enforcement notified  Family notified  APS notified  CPS notified | | | | | | | DSHS Communications notified  Medicaid Control Fraud Unit  Department of Health  DSHS Notified | | | | | | | | | | Media has contacted Agency  None  Other:  **Date of referral:** | |
| **FOLLOW-UP/CORRECTIVE ACTION INFORMATION** | | | | | | | | | | | | **THIS INCIDENT DOES NOT REQUIRE FOLLOW-UP** | | | | | | |
| Follow-up Date: | | Action taken: | | | | | | | | | | | | | | | | |
| Follow-up Date: | | Action taken: | | | | | | | | | | | | | | | | |
| Corrective Action Plan?  YES NO  N/A | | Describe CAP briefly: | | | | | | | | | | | | | | | | |
| Case closed?  YES  NO | | | Date closed: | | | | | | | Incident Manager Comments: | | | | | | | | |