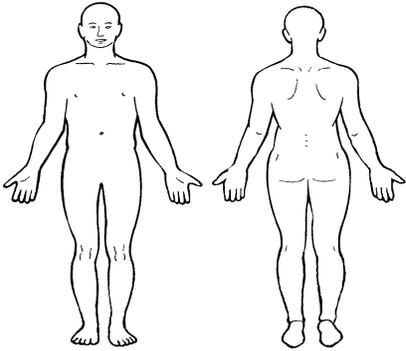


## SOLA Incident Report

<b>PARTICIPANT INVOLVED</b>			
NAME OF PARTICIPANT INVOLVED			
ADDRESS		CITY	STATE      ZIP CODE
INCIDENT TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	INCIDENT DATE	LOCATION OF INCIDENT	
INCIDENT WAS: <input type="checkbox"/> Intentional <input type="checkbox"/> Accidental <input type="checkbox"/> Unknown		TYPE OF INCIDENT <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Alleged Abuse <input type="checkbox"/> Medication Error <input type="checkbox"/> Other:	
<b>IF INDIVIDUAL WAS INJURED OR ASSAULTED FILL OUT THE FOLLOWING:</b>			
INJURY CAUSED BY: <input type="checkbox"/> Other Individual <input type="checkbox"/> Staff <input type="checkbox"/> Self <input type="checkbox"/> Equipment <input type="checkbox"/> Unsafe practice <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
TYPE AND DESCRIPTION OF INJURY (CUT, BRUISE, SCRATCH, NONE, ETC.)			
BODY PART INJURED (NECK, LEFT ARM, ETC.) INDICATE AT RIGHT:			
<b>INCIDENT DESCRIPTION</b>			
Describe what happened and action(s) taken:			

INTERVENTION					
<input type="checkbox"/> Positive Behavior Support Plan followed <input type="checkbox"/> Cross-System Crisis Plan followed <input type="checkbox"/> Medication (including PRN) <input type="checkbox"/> Medical Treatment in Hospital or Physician's Office <input type="checkbox"/> Other:					
REPORTING EMPLOYEE					
NAME OF REPORTING EMPLOYEE				TITLE	
DATE OF REPORT	TIME OF REPORT	<input type="checkbox"/> AM <input type="checkbox"/> PM	INCIDENT DOCUMENTED IN PARTICIPANTS NOTES		
<input type="checkbox"/> Yes <input type="checkbox"/> No					
List witnesses involved:					
NAME			TITLE		
Person(s) notified:					
NAME			TITLE		
RCS NOTIFIED	RCS WORKER NAME (IF ANY)			DATE	TIME
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> AM <input type="checkbox"/> PM
Regarding confidentiality of employee making report to RCS:					
<input type="checkbox"/> I waive my right to confidentiality. My name can be shared. <input type="checkbox"/> I choose to have my name remain confidential.					
REPORTING EMPLOYEE'S SIGNATURE					DATE
IMMEDIATE SUPERVISOR REVIEW					
NAME OF IMMEDIATE SUPERVISOR			TITLE		DATE
	YES	NO	DATE	TIME	
Family/Guardian notified?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM
RCW notified?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM
APS notified?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Nurse Delegator notified?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Medical Professional notified?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM
CRM notified?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Entered in IR System?	<input type="checkbox"/>	<input type="checkbox"/>	IR Number: _____		