FAR NORTHERN REGIONAL CENTER
VENDOR UNUSUAL INCIDENT/INJURY/DEATH REPORT

Please use "NA" (Not Applicable) where needed to complete this form.

NAME OF FACILITY:_____
(PLEASE PRINT)

FACILITY ADDRESS: _____

FACILITY TELEPHONE NUMBER: (_____) _____ **EXT:** _____
Area Code

DATE OF INCIDENT:_____/_____/_____ **TIME OF INCIDENT:**_____ **AM/PM**
Month (XX) Day (XX) Year (XXXX)

CONSUMER NAME:_____ **CONSUMER UCI#:**_____
(PLEASE PRINT)

NAME OF SERVICE COORDINATOR:_____
(PLEASE PRINT)

INCIDENT TYPE:

- ☐ **Alleged Consumer Abuse/Neglect**
- ☐ **Alleged Violation of Rights**
- ☐ **Arrest/Incarceration**
- ☐ **Assaultive/Self-Injurious Behavior**
- ☐ **Death**
- ☐ **Fire**
- ☐ **Hospitalization-Planned**
- ☐ **Hospitalization-Unplanned**
- ☐ **Injury – First Aid Only**
- ☐ **Injury – Med Trmt Required**
- ☐ **Involuntary Psych Admit**
- ☐ **Medical Emergency (ER/911)**
- ☐ **Medication Error**
- ☐ **Missing**
- ☐ **Sexual Incident**
- ☐ **Suicide Attempt**
- ☐ **Victim of a Crime**

☐ **Other**_____

PROTECTIVE AGENCIES/INDIVIDUALS NOTIFIED: (Specify names and telephone numbers)

☐ **DEPARTMENT OF HEALTH SERVICES (DHS)** _____

☐ **DEPARTMENT OF SOCIAL SERVICES/COMMUNITY CARE LICENSING (DSS/CCL)**_____

☐ **ADULT/ CHILD PROTECTIVE SERVICES**_____

☐ **OMBUDSMAN**_____

☐ **PARENT/GUARDIAN/CONSERVATOR**_____

☐ **LAW ENFORCEMENT**_____

☐ **DAY PROGRAM**_____

☐ **PHYSICIAN/HOSPITAL**_____

☐ **OTHER ENTITY**_____

CONSUMER NAME_____ **UCI #**_____
(Last) (First) (MI)

DESCRIBE INCIDENT IN DETAIL:

When identifying other consumers, use *ONLY* the initials of that consumer.
Please attach additional pages, as needed.

LOCATION OF INCIDENT_____

EXPLAIN IN DETAIL IMMEDIATE ACTION(S) TAKEN: (Include names of person(s) contacted)

MEDICAL TREATMENT? ☐ YES ☐ NO If "YES", Describe treatment.

a. WHERE TREATED:_____ **BY WHOM:**_____
b. FOLLOW-UP TREATMENT, IF ANY:_____

FACILITY RISK MANAGEMENT ACTION TAKEN OR PLANNED:

Agency Contact if additional information is required:

Print Name **Date**

Telephone Number **(E-mail address)** **Facility Name**

FAR NORTHERN REGIONAL CENTER

Special Incident Report (SIR) Flow Chart
For Vendor or Long-Term Care Facility

W H A T T O D O W H E N A "S P E C I A L I N C I D E N T" O C C U R S

Incident occurs that is either witnessed, suspected or staff informed of incident

STEP 1: PHONE IMMEDIATELY

Call and notify Far Northern Regional Center. Call and notify appropriate licensing agency, conservator or authorized representative.

IMMEDIATELY but no later than 24 hours

STEP 2: WRITE

When in doubt, write it out
Staff person involved in the incident or designated facility reporter
Complete FNRC SIR form

~For Mandated Reporting Incidents Only~
Send written report to appropriate agency

IMMEDIATELY but no later than 48 hours

STEP 3: FAX

Fax completed FNRC SIR form to:
Far Northern Regional Center to the attention of the consumer's Service Coordinator

REDDING

Far Northern Regional Center
P. O. Box 492418
Redding, CA 96049-2418
(530) 222-4791
(530) 222-8908 - FAX

CHICO

Far Northern Regional Center
1377 E. Lassen Ave.
Chico, CA 95973
(530) 895-8633
(530) 332-1497 - FAX