VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY
RECIPIENT INCIDENT REPORT

SUBMIT TO THE OFFICE OF RECIPIENT RIGHTS WITHIN 24 HOURS OF THE INCIDENT

** DO NOT PHOTOCOPY **

1. Demographics

Name of Recipient Served: ______________________ **Recipient EMR ID#** ____________

Is the recipient on a waiver: ☐ HSW ☐ CWP ☐ SED **Self-Directed Services:** ☐ Yes ☐ No

If the Recipient Lives in an AFC/SIL Please Complete the Following:

Provider Name: ____

Name of Home: ____

2. Description of the Incident

Date Incident Occurred/Noticed: ______________ **Time Incident Occurred/Noticed:** ________

Date Incident Reported: ______________ **Time Incident Reported:** ________

Is this an incident that is addressed in the IPOS or a Behavior Support Plan? ☐ Yes ☐ No

A. Site Where Injury/Incident Occurred

☐ BHC	☐ New Outlook	☐ Vehicle: → ☐ Agency OR ☐ Personal
☐ HFRC	☐ Recipient's Home	☐ Community (specify): ______________
☐ HSB	☐ SHOP	☐ School (enter name): ______________
☐ Lifespan	☐ The Junction	☐ Other (describe): ______________

B. Area Where Injury/Incident Occurred

☐ Bathroom	☐ Hallway	☐ Work Site (enter name): ______________
☐ Bedroom	☐ Living Area	☐ Outdoors (specify): ______________
☐ Class/Training Area	☐ Staff Office	☐ Other (describe): ______________
☐ Dining Area	☐ Waiting Area	

C. Detailed Description of Incident/Injury Including Details of What Led up to the Incident.

Attach another sheet if more space is needed.

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D. Techniques Used During Incident

☐ Physical Intervention (describe):______________________________

**If physical intervention used, complete the Physical Intervention Report form*

☐ Supporting (describe)

☐ Verbal De-escalation

☐ Other (describe): ______________________________

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E. Type of Incident (check all that apply)

☐ Accident that could result in injury
☐ Elopement
☐ Problematic behaviors not addressed in a behavior treatment plan/tracking form
☐ Altered state of mind
☐ Emergency Services/ 1st Responder Interaction
☐ Suspected abuse & neglect
☐ Use or possession of weapons
☐ Any rights violation
☐ Incidents involving illness/medical
☐ Threatening/attempted suicide or homicide
☐ Use or possession of licit or illicit substances
☐ Biohazard accident
☐ Involvement of other agencies
☐ Use of any Physical Management
☐ Death of recipient
☐ Medication error(s)
☐ Other: ___________________________

F. Type of Injury (check all that apply)

☐ Abrasion/Scratch ☐ Burn ☐ Fracture/Break ☐ Sprain
☐ Bite ☐ Concussion ☐ No apparent injury ☐ Swelling
☐ Bruise ☐ Dislocation ☐ Other:___________________________

G. Seriousness of Injury

☐ Fatal (See Death Reporting Procedure)
☐ None apparent
☐ Non-serious (minor first aid)
☐ Serious (Treated by Physician, Hospital or Paramedics)

H. Treatment Provided (check all that apply)

☐ Ambulance → ☐ No Treatment Provided → ☐ On Site Treatment Provided → ☐ Transported to Hospital
☐ CMH Nurse ☐ First aid by staff on site ☐ Private Physician
☐ Emergency Room ☐ None ☐ Urgent Care/Walk-In Clinic
☐ Hospitalized →Admission Date: ______ →Discharge date: _________ ☐ Other: ___________________

I. Witness(es)Name and Title/Relationship to Recipient

Name: ________________________________ Title/Relationship: ____________________
Name: ________________________________ Title/Relationship: ____________________
Name: ________________________________ Title/Relationship: ____________________
Name: ________________________________ Title/Relationship: ____________________

3. Notification (Persons Contacted)

☐ Case Manager Date: ______________ ☐ Protective Services Date: ______________
☐ Guardian Date: ______________ ☐ Provider Date: ______________
☐ Licensing Date: ______________ ☐ Psychologist Date: ______________
☐ Nurse Date: ______________ ☐ Recipient Rights Date: ______________
☐ Other: ____ Date: ______________

4. Name and Title of Person Who Completed This Form

Name (*please print*): ________________________________ **Title:** ____________________

Signature: ________________________________ **Date:** ____________________

5. Supervisor Review

A. To the best of your knowledge, was this incident preventable? ☐ Yes ☐ No

Explain: ______________________________

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B. What steps have been/will be taken to prevent future occurrences?

Explain: ______________________________

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C. Printed Name of Supervisor: ______________________________

Supervisor Signature: ______________________ **Date:** ____________

Is this incident documented in VieWPoint?

☐ **Yes** ☐ **No Staff who documented (*Please Print*):** ______________________ **Date:** ____________

6. Recipient Rights/Quality Assurance Notes:

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A. Name of Recipient Rights Officer: Candice Kinzler **Date:** ____________

Submit Completed Incident Report and Attachments to the Office of Recipient Rights
Fax: 269-256-6526
Email: Incidentreporting@vbcmh.com
To verbally report an incident that involved any emergency personnel please call : 269-655-3315