RCBMR/DD Use Only	
SSA Reviewing:	
Date Reviewed:	

RCBDD Incident Report

Behavior ______ **Illness** ______ **Injury** ______ **Accident** ______ **Employee** ______ **Other** ______

Consumer's Name: ______ **PPI's Name:** ______ **PPI Relationship:** ______

Consumer's Address: ______

Agency Reporting: ______ **Staff Reporting:** ______

Other persons involved or observing: ______

Date of Incident: ______ **Time of Incident:** ______ **AM** **PM** **Location of Incident:** ______

Witness Statements:

A) – What was happening before the unusual incident occurred?

Include environmental conditions, actions of individual, actions of others, mental/medical state of consumer, activities/tasks going on, etc.

B) – What Happened during the unusual incident?

Actions of individual and others involved (include all verbal/physical interventions used if manual restraint/escort used, give total time used)

C) – What Happened after the unusual incident?

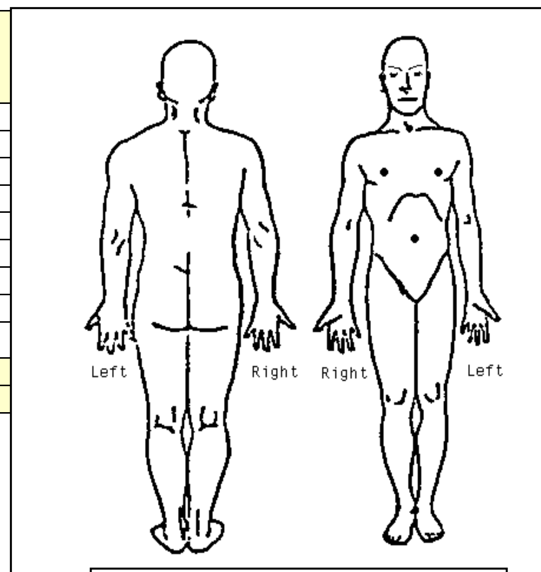
Include immediate actions taken to ensure health and welfare of the individual and any at risk individuals:

If illness/injury to individual occurred, please check all that apply: ______ **Scratch** ______ **Bite** ______ **Cut** ______ **Swelling** ______ **Bruise** ______

Bruise color & Size: ______ **Injury/Illness (describe):** ______

If medical attention was given, please explain below (including nurse notification): ______

Identify notifications with check mark:	Faxed	Phoned	Copied	Mailed	Date	Time	Initials of person making notifications	Person Notified
RCBDD								
Provider/Agency								
Guardian/Family Member								
Advocate								
Medical/Nurse								
Law Enforcement								
Children Services								
Other (specify below)								
FOR COUNTY BOARD USE ONLY								
CB Follow-up:								



Please indicate area of injury to consumer above.

Provider - Complete other side of this form for M/UI's that need investigation

Signature (person completing report)	Date	Signature	Date	Signature	Date

Causes and Contributing Factors of UI
(This area is for providers to complete for UI investigations)

List all causes and contributing factors that lead to this incident:

Prevention Plan for UI's
(This area is for providers to complete for UI investigations)

Preventative Measures: *(Please include who will implement measures and date they will be completed)*

Please attach all signature pages for re-training, addendums, etc. to IR, or send to SSA when completed

Signature of person completing cause and contributing factors and prevention	Date

County Board Follow-up on UI Investigations			
Has all follow up above been completed?		Please indicate below what needs to be completed and when provider will complete	
Does team or team member have other items that need addressed related to this incident?		Describe below	
Administrative Actions: (please list all actions taken by administration of your agency)			
Signature of SSA reviewing IR			Date

Provider Use Only			
Data Logged:			
Initials:			
UI#:			
MUI:	Yes		No