

# INCIDENT REPORT (SFY 2009)

Case #:

## SECTION 1 – CONSUMER INFORMATION

Name of Consumer	*First:	Middle:	Last:
Social Security #	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		*DOB
Residence Address	*Street Address:	*City:	*Zip: <span style="float: right;">*Phone:</span>

<b>*Consumer Competency Level</b>	<b>*ADLs (Consumer Needs Assistance With) Check All That Apply</b>
<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low	<input type="checkbox"/> Walking <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bathing <input type="checkbox"/> Eating <input type="checkbox"/> Transfer <input type="checkbox"/> Total Care <input type="checkbox"/> None Verbal <input type="checkbox"/> Yes <input type="checkbox"/> No

**Diagnosis(es):**

**Name of Doctor & Phone #:**

**List Consumer's Current Medications or attach Medication Administration Record (MAR):**

## SECTION 2 – DESCRIPTION OF INCIDENT (Staff person with the most direct knowledge of incident fills out this section.)

### \*TYPE OF ALLEGED INCIDENT

Reminder: Abuse, Neglect and Exploitation must be reported to APS via Fax: (505) 476-4913 or Phone (866) 654-3219

<input type="checkbox"/> Abuse	<input type="checkbox"/> Neglect	<input type="checkbox"/> Exploitation	<input type="checkbox"/> Natural/Expected Death
<input type="checkbox"/> Unexpected Death	<input type="checkbox"/> Emergency Services	<input type="checkbox"/> Law Enforcement Involvement	<input type="checkbox"/> Environmental Hazard
<b>Additional Incident Type for Use <u>ONLY</u> by Licensed Healthcare Facilities or Agencies</b> <input type="checkbox"/> Injuries of Unknown Origin			

Person responsible for individual's care at time of incident:

If this person is employed by a provider agency, which agency:

Has this happened before?  Yes  No Was provider notified of incident?  Yes  No

Were other consumers/individuals present?  Yes  No If, Yes, Other Consumer's Initials:

Was anyone else present at the time of the incident:  Yes  No If Yes, Identify below:

Name:	Title or Relationship:	Phone:
Name:	Title or Relationship:	Phone:
*Date Incident Occurred:	*Time:	* <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Unknown

**Describe what you saw and/or what you heard in order of occurrence:**

**\*Before the Incident:**

**\*During the Incident:**

**\*After the Incident:**

### Person Completing Sections 1 & 2

*Confidentiality Desired: <input type="checkbox"/> Yes <input type="checkbox"/> No	*Name:	*Agency:	*Title/Relationship:	*Phone:	*Date Completed:	*Time Completed
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**DOH FAX (800) 584-6057 e-mail: [incident.management@state.nm.us](mailto:incident.management@state.nm.us)**  
**When faxing information that is not on this form please label it with consumer's name and incident date.**

Name of Consumer	First:	Middle:	Last:	SSN:	Date of Incident:
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**SECTION 3 – AGENCY / FACILITY INFORMATION**

Reporting Agency:			Incident Coordinator:		
Address:	City:	Zip:	County:	Phone:	

**SECTION 4 – ADMINISTRATIVE INFORMATION** \*Check the applicable box(s) below:

DD Waiver [If DD check Jackson:  YES  NO]  D&E Waiver  Medically Fragile Waiver  DD/State General Fund  
 ICFMR  Family/Infant/Toddler  TBI  Diagnostic & Treatment Facility  Limited Diagnostic & Treatment Facility  
 Adult Residential Care Facility  Home Health  Hospice  Nursing Facility  Specialty Hospital  Other

**DD Programs ONLY: Type of residential services being received by this consumer**

Assisted  Supported  Family Living  Supervised  Respite  None

**INITIAL ACTIONS TAKEN BY THE AGENCY/FACILITY TO ASSURE HEALTH & SAFETY:**

Was law enforcement contacted?  Yes  No  
 Is the consumer still in the facility/agency?  Yes  No

**PLANS FOR FURTHER ACTIONS IN RESPONSE TO THE INCIDENT:**

**SECTION 5 – NOTIFICATIONS TO AGENCIES REQUIRED**

Always notify DOH/DHI within 24 hours via FAX: (800) 584-6057  
 Notify Adult Protective Services/Child Protective Services to Report Abuse, Neglect, Exploitation ONLY  
 CPS FAX: (505) 841-6691 APS FAX: (505) 476-4913 e-mail: [incident.management@state.nm.us](mailto:incident.management@state.nm.us)  
 or Phone APS: (866) 654-3219

Name of Person Phoned:

<b>Legal Guardian</b> <input type="checkbox"/> None <input type="checkbox"/> Notified	Guardian Name & Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:		State:	Zip:
<b>Independent Case Manager</b> <input type="checkbox"/> None <input type="checkbox"/> Notified	Case Management Agency Name:			Person Making Contact:	
	Case Manager Name & Phone #:			Date:	Time:
	Street Address:	City:		State:	Zip:
<b>Other</b> <input type="checkbox"/> None <input type="checkbox"/> Notified	Name & Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:		State:	Zip:

**Person Completing Sections 3, 4 & 5:**

*Name:	*Title/Relationship:	*Phone:	*Date Completed:	*Time Completed:
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By typing your name below you are effectively signing this document. Your typed name is acceptable as a replacement for your written signature.

\*Name:

\*Date:

## OPTIONAL INFORMATION

**(If choosing to file this page, it is due within 72 hours of initial report. This page is NOT required.)**

Name of Consumer	First:	Middle:	Last:	SSN: - -	Date of Incident
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**SECTION 6 – ADDITIONAL INFORMATION** Information to be provided in cases of medical emergency services.

YES  NO Hospital Admission Required? If Yes/Discharge Date:

YES  NO Medical Records FAXED to DHI on (Date):

YES  NO Diagnosis(es) given at Emergency Intervention:

Comments:

Does this consumer have an existing medical diagnosis that may impact the reported incident?

YES  NO If yes, provide DX:

If this report involves abuse, neglect or exploitation & the responsible provider wishes to confirm that a person in our employ has committed the alleged event, check the appropriate box, then sign and date at the bottom of this page:

Abuse       Neglect       Financial Exploitation

What measures have been put in place to remedy the situation and to ensure the health and safety of the consumer?

Additional Information that may be pertinent to this incident?

Authorized by:	Last Name:	First Name:	Title:	Agency:
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