Catholic Charities Disabilities Services
Community Services Incident Report

Individual's Name: _____ **Age:** _____ **Sex:** _____

Individual's Address: _____

Developmental Disability: _____

Other Diagnoses (psychiatric, medical) :_____

Date/Time of Incident: _____ **Location of Incident**: _____

What Happened Before the Incident?

_____

_____

Who Else Was There? (Witnesses)

_____

_____

Classification of Incident: _____ Serious Injury _____ Minor Injury

_____ Missing person _____ Behavioral Incident _____ Illness

_____ Involvement of Adult or Child Protective Services _____ Sensitive

_____ Involvement of Law Enforcement or Possible Criminal Act

Briefly Describe Incident:

_____

_____

_____

_____

_____

_____

Could Anything Have Been Done to Prevent This?

_____

_____

Notifications and Follow-Up: (Actions on CCDS' part)

_____

_____

Was a Bruise Chart Filled Out? **Yes ( ) or No ( )**

For Office Use Only: **Notification**: (HCBS Waiver Incident Review Committee Members, please date and initial)

_____ Assistant Executive Director

_____ Director of HR/QA

_____ Director of Community Clinical

_____ Director of Community Res. Supports

_____ Service Coordination IRC Representative

_____ Residential Habilitation Coordinator IRC Representative

_____ Quality Improvement Specialist

DDSO notified? YES or **NO**

If Yes:

Date: _____

Individual notified: _____

By Whom?: _____

_____

Print Name of Person Completing Form **Signature** **Title** **Date**

_____

Supervisor's Name (if applicable) **Signature** **Title** **Date**

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