CONFIDENTIAL

Department of Human Services

INITIAL INCIDENT REPORT FORM

DIVISION OF DEVELOPMENTAL DISABILITIES

INTER-AGENCY ADVISORY, CONSULTATIVE, DELIBERATIVE MATERIAL

DDD – Provider/Agency/Facility	Date of Incident	Time of Incident	Shift

Address (community only)	Residence Type	VID#	Region	Incident Code

Reporting Code: (check one) ☐ A+ ☐ A ☐ B **Incident Type Code:**

Incident Type:

Location of Incident:

Description:

Role	Name (last, first)	Status	Consumer ID #/Staff Title	Age	Sex	Injury Level
	Guardianship Status:		**Case Manager:**			
	Guardianship Status:		**Case Manager:**			
	Guardianship Status:		**Case Manager:**			
	Guardianship Status:		**Case Manager:**			
	Guardianship Status:		**Case Manager:**			
	Guardianship Status:		**Case Manager:**			
	Guardianship Status:		**Case Manager:**			

Codes for Role:	AP = Alleged Perpetrator	VS = Victim/Subject		
Codes for Status:	SR = Services Recipient	E = Employee	V = Visitor	
Codes for Injury	Major	Moderate	Minor	None

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DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

DDD – Provider/Agency/Facility	Date of Incident	Time of Incident	Shift

Incident Status: (check one) ☐ Pending ☐ Closed

Date First Known to Staff:

Who Has Been Notified: (check all that apply)

☐ DYFS
☐ Special Response Unit
☐ Family
☐ Guardian
☐ Ombudsman
☐ Office of Licensing
☐ B Guardianship Serv.
☐ Medical Examiner
☐ Adult Protective Serv.
☐ Dept. of Health
☐ Human Services Police
☐ Prosecutor
☐ Dept Comm Affairs
☐ Other

Name	Org/Relation	Date	Time

Actions Taken or To Be Taken:

☐ Transfer of Alleged Perpetrator
☐ Transfer of Alleged Victim
☐ Interdisciplinary Team Review
☐ Further Investigation
☐ Community Services Follow-up: _____
☐ Policy/Procedure Change
☐ Training
☐ Changes in Facility
☐ None/Closed no further action
☐ Patient Treated by: _____
☐ Autopsy Scheduled: _____
☐ Other: _____

Witness Names:	Titles:

Additional Comments:

The information contained herein is, to the best of my knowledge, a true and accurate representation of the facts and events that relate to this incident. I understand that falsification, misrepresentation or distortion of any aspect of this written account will be due cause for the initiation of appropriate disciplinary and/or legal action by the Division of Developmental Disabilities.

Reported by: _____ **Title:** _____ **Phone:** _____

For additional details: _____ **Title:** _____ **Phone:** _____

For D.D.D. Use Only

Reported to UIR Coor.: **Date:** **Time:**