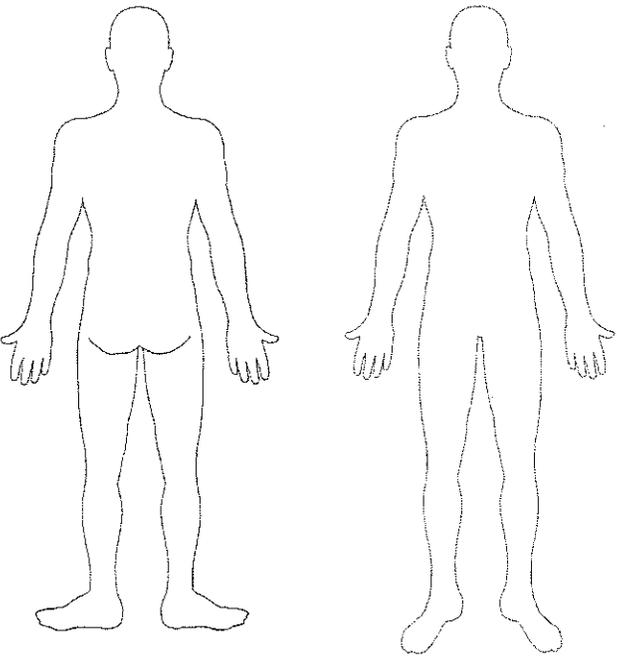


Adult Foster Home Incident Report

| | | |
|---|---|-------------------|
| Resident's name: | Date of incident: | Time of incident: |
| Type of incident: <input type="checkbox"/> Accident <input type="checkbox"/> Medication error <input type="checkbox"/> Complaint <input type="checkbox"/> Behavioral <input type="checkbox"/> Suspected abuse or neglect – if checked, list date reported to local office: | | |
| Where did incident occur? List any other residents involved: | Was incident witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, by whom? | |
| Details of incident and description of any injuries: | | |

Specific action(s) taken by staff:

Mark on figures any body areas injured (i.e., bruises, cuts, abrasions, broken bones, etc)

| | |
|--|---|
|  | Licensee notified?: <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Date: _____ Time: _____ |
| | Primary care practitioner notified?: <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Date: _____ Time: _____ |
| | Family notified?: <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Date: _____ Time: _____ |
| | Case manager notified?: <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Date: _____ Time: _____ |
| | Licensor notified?: <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Date: _____ Time: _____ |
| | Mental health professional notified?: <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Date: _____ Time: _____ |

Follow-up plan:

Name of person completing form:

Signature:

Date:

Time:

Licensee signature acknowledging review of incident report:

Date of review:

Date signed: