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

Sojourners Care Network Incident Report

Sojourners Care Network Use Only				
Staff Review:				
CQI Logged:				
MUI		Yes		No
MUI Type:				

Behavior ____ Illness ____ Injury ____ Accident ____ Employee ____ Other _____

Youth's Name: _____ PPI's Name: _____ PPI Relationship: _____

Youth's Address: _____

Agency/Organization / Reporting: _____ Staff/Caregiver 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?

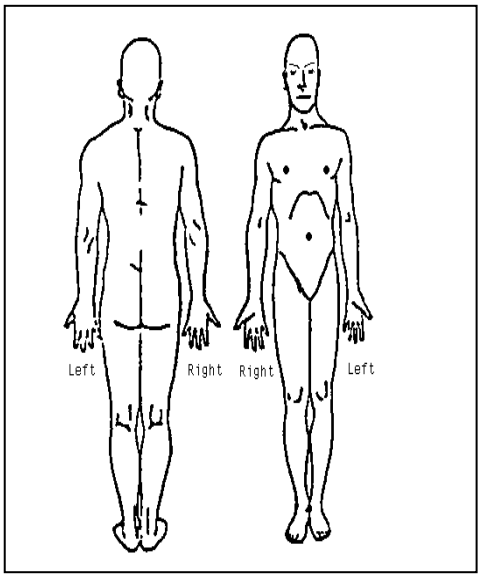
Include immediate actions taken to ensure health and welfare of the individual and any at-risk individuals:

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: _____

Identify notifications with check mark:	Faxed	Phoned	Copied	Mailed	Date	Time	Initials of person making notifications	Person Notified
Sojourners Care Network								
Provider/Agency								
Parent/Guardian								
Children's Services								
Medical/Physician								
Other (specify below)								



Please indicate area of injury to consumer above.

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

FOR SOJOURNERS USE ONLY
Follow-up:

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

Sojourners Care Network Incident Report

Sojourners Care Network Use Only				
Staff Review:				
CQI Logged:				
MUI		Yes		No
MUI Type:				

Behavior ____ **Illness** ____ **Injury** ____ **Accident** ____ **Employee** ____ **Other** ____

Youth's Name: ____ **PPI's Name:** ____ **PPI Relationship:** ____

Youth's Address: ____

Agency/Organization / Reporting: ____ **Staff/Caregiver Reporting:** ____

Other persons involved or observing:

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

Signature (person completing report)	Date	Signature	Date	Signature	Date

Complete This Side for UI or MUI's that need Investigation

Behavior Support Information *(Complete if this is for an UBS)*

Does this individual have a Behavior Support Plan in the environment UI or MUI happened? Yes ____ No ____

If this was an Unapproved Behavior Support please complete the following:

Reason for Restraint: Method not in plan ____ No Plan ____ Unapproved Manner ____

Type of restraint used:

Time Out or Time Out Room ____ Physical ____ Chemical ____ Mechanical ____ With hold food/rewards ____

If individual was restrained please complete how long restraint lasted Started ____ Ended ____ Total Time ____

Was there any injury related to this UBS? If yes please indicate type and location in appropriate spaces on front page.

Name of staff(s) that restrained or implemented UBS

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	

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

Sojourners Care Network Incident Report

Sojourners Care Network Use Only				
Staff Review:				
CQI Logged:				
MUI		Yes		No
MUI Type:				

Behavior ____ **Illness** ____ **Injury** ____ **Accident** ____ **Employee** ____ **Other** _____

Youth's Name: _____ **PPI's Name:** _____ **PPI Relationship:** _____

Youth's Address: _____

Agency/Organization / Reporting: _____ **Staff/Caregiver Reporting:** _____

Other persons involved or observing:

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

Administrative Actions: (please list all actions taken by administration of your agency)

_____

Signature of Staff reviewing IR Date