|  |  |  |  |
| --- | --- | --- | --- |
| Date Reported to the DBHR:       | Date of Incident:       | Time of Incident:       (*24 hour)* | Location of incident:      |
| Reporting Site: Provider Agency:       | Name of Reporter:       | Phone/Email:      /      |
| Brief description of the incident:   |
| [ ]  UNSUBSTANTIATED |  [ ]  SUBSTANTIATED  | [ ]  UNDER INVESTIGATION/UNDETERMINED |
| [ ]  POTENTIAL FOR MEDIA COVERAGE?  | [ ]  PROPERTY DAMAGE? |
| **TYPE OF INCIDENT** *Instructions: Please click on the appropriate category for drop down menu where indicated by an asterisk* |
| \*\* | \* |
| **PATIENT(1) INFORMATION** | **PATIENT(2) INFORMATION**  |
| Patient Identifier:       | Name: Last, First       | Patient Identifier:       | Name: Last, First        |
| **PATIENT(3) INFORMATION** | **PATIENT(4) INFORMATION** |
| Patient Identifier:       | Name: Last, First       | Patient Identifier:       | Name: Last, First       |
| **STAFF (1) INFORMATION** | **STAFF (2) INFORMATION** | **STAFF (3) INFORMATION** |
| Name: Last, First      | Name: Last, First       | Name: Last, First      |
| **VISITOR/OTHER INFORMATION** |
| Name: Last, First      | Relationship:      | Other Pertinent Information Related to the Visitor:       |
| **OTHER AGENCY/FACILITIES NOTIFIED/INVOLVED** |
| [ ]  Law enforcement notified[ ]  Family notified[ ]  APS notified[ ]  CPS notified | [ ]  DSHS Communications notified [ ]  Medicaid Control Fraud Unit[ ]  Department of Health[ ]  DSHS Notified | [ ]  Media has contacted Agency[ ]  None[ ]  Other:      **Date of referral:**       |
| **FOLLOW-UP/CORRECTIVE ACTION INFORMATION** | [ ]  **THIS INCIDENT DOES NOT REQUIRE FOLLOW-UP**  |
| Follow-up Date:       | Action taken:      |
| Follow-up Date:       | Action taken:      |
| Corrective Action Plan? [ ] YES [ ] NO [ ]  N/A | Describe CAP briefly:       |
| Case closed? [ ]  YES [ ]  NO | Date closed:      | Incident Manager Comments:      |