06MP046E-001

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Incident Report

Staff completes this form to report any critical and non-critical incident involving a person who receives Developmental Disabilities Services Division (DDSD) services.

Name	Date of report
Provider agency	Incident location
Date of incident ☐ observed ☐ discovered	Time of incident ☐ a.m. ☐ p.m.

Critical incidents, check all that apply. Notify staff per OAC 340:100-3-34. Any critical incident requires immediate verbal notification to DDSD case manager or, if incident occurs after regular working hours, DDSD on-call staff.

☐ Suspected abuse, neglect, or exploitation, notified:
  ☐ Adult Protective Services ☐ Office of Client Advocacy ☐ Child Welfare Services
☐ Threat of suicide ☐ Attempt of suicide
☐ Death
☐ Unplanned hospital admission:
  ☐ psychiatric facility ☐ result of medication error ☐ transport by ambulance
☐ Medication event resulting in need for emergency medical treatment
☐ Law enforcement involvement: ☐ criminal ☐ behavioral
☐ Loss of property more than $500:
  ☐ fire ☐ natural disaster ☐ theft ☐ behavioral destruction
☐ Missing person:
  ☐ lost ☐ in danger ☐ community protection issue ☐ police notified
☐ Unusual or significant incident that may attract media attention
☐ Use of highly restrictive procedure:
  ☐ p.r.n. medication for behavioral control,
    medication _____ time _____ dose _____
  ☐ physical hold, amount of time in hold _____
  ☐ authorized in Protective Intervention Plan (PIP)
  ☐ injury
  ☐ other, describe _____

Non-critical incidents, check all that apply.

☐ Injury or ☐ Unplanned health-related event:
  ☐ treatment not required ☐ treatment, consultation, or both by physician
  ☐ treatment by other than physician
  ☐ emergency room visit ☐ transport by ambulance

☐ Physical aggression toward:
☐ self, self–injurious behavior (SIB) ☐ staff ☐ others
☐ Fire setting
☐ Deliberate harm to an animal
☐ Loss of property less than $500:
☐ fire ☐ natural disaster ☐ theft ☐ behavioral destruction
☐ Vehicle accident
☐ Suspension, removal, or termination of person's program including employment
☐ Medication event:
☐ dose at wrong time ☐ missed dose ☐ wrong dose
☐ wrong medicine ☐ wrong route ☐ refused medication
☐ documentation incorrect ☐ incorrect label or instruction
☐ no medical treatment required
☐ other significant occurrence involving medication _____

Incident details. Describe what happened from beginning to end of incident, include who, what, when, where, how, and why. Use additional pages as needed.

Person reporting signature and title Date

Action taken:

Program coordinator signature Date

Follow-up/action needed: ☐ Yes ☐ No

Explain:

Case manager signature Date

Routing: Original – service recipient home record
Copy – any incident, DDSD case manager
Copy – critical incident only, DDSD State Office, attention Kim Akins, fax (405) 522-3037 or e-mail Kim.Akins@okdhs.org