CONFIDENTIAL

REPORTABLE INCIDENT

Department of Intellectual and Developmental Disabilities

Name of Person Served _____ SSN _____ Date of Incident / /

Please Type Last, First, MI Time of Incident : AM ☐ PM ☐

Region M **Provider Responsible** **Provider Code** **Provider Reporting** (if different)

DIDD Investigator must be notified within 4 hours (1 hour for Public ICF/ID) for alleged abuse, neglect, exploitation, serious injury of unknown cause, for any unexpected, unexplained, or suspicious death, and for any injury that raises the suspicion of abuse or neglect.

This incident was ☐ **Witnessed** by Select One or ☐ **Discovered**

➢ **Where incident occurred** Address / Site of Incident _____

Check one ☐ Home – Inside ☐ Home - Outside ☐ Vehicle ☐ Day Program/Work/School

☐ Community-Supervised ☐ Community-Unsupervised ☐ Unknown

➢ **This incident required** ⇨ Check all that apply

☐ Hospital Emergency Room ☐ Manual Restraint ☐ MH Mobile Crisis Team ☐ Police ☐ 911 Call

☐ X-ray (to rule out fracture) ☐ Mechanical Restraint ☐ Emergency Psychotropic Medication ☐ Incarceration

☐ Hospitalization - Medical ☐ Protective Equipment ☐ Hospitalization - Psychiatric ☐ Abdominal Thrust (Heimlich) ☐ CPR

➢ **Brief description of incident** - (what/where/when/who)

➢ **Description of injury** to Person Served: If applicable. Describe type, size, color, location on body; location of treatment; etc.

If this is a reportable behavior/psychiatric incident involving physical aggression, self-injurious behavior or property destruction; did anyone other than the person served require treatment beyond first aid?

☐ Housemate ☐ Staff ☐ Private Citizen/Other

➢ **Notified**	☐ Legal Representative	☐ ISC Provider	☐ APS 888-277-8366 DCS 877-237-0004	☐ DIDD Investigations 888-633-1313
Date & Time	/ / : **AM ☐ PM ☐**	/ / : **AM ☐ PM ☐**	/ / : **AM ☐ PM ☐**	Investigator's Name

➢ **Notified**	☐ Chief Officer / AOD (Public ICF/ID)	☐ Regional Office AOD 615-218-0784	Date/Time
Date & Time	/ / : **AM ☐ PM ☐**	/ / : **AM ☐ PM ☐**	/ / : **AM ☐ PM ☐**

➢ **Person Writing This Report** Print Name/Title: _____ ,

Date /Time completed: / / @ : **AM ☐ PM ☐** Signature: _____

➢ ***Incident Management Coordinator Review*** Reviewed by (Name/Title): ,

(If applicable, describe staffing or supervision issues below.)

➢ **Type of incident** ALL **BOLDED** TYPES MUST BE REPORTED TO DIDD INVESTIGATIONS **WITHIN 4 HOURS**

☐ **Alleged Abuse** ☐ **Alleged Neglect** ☐ **Alleged Exploitation**

☐ **Serious Injury – Unknown Cause** ☐ **Suspicious Injury (abuse or neglect suspected)** ☐ Death

☐ Reportable Behavioral/Psychiatric Incident ☐ Sexual Aggression ☐ Missing Person (> 15 minutes)

☐ Reportable Medical Incident ☐ Criminal Conduct ☐ Other Type of Incident, specify

☐ Reportable Staff Misconduct – No injury and risk is minimal because… (describe below):

Additional Information to clarify this incident such as staffing requirements, LON and/or medical diagnosis:

☐ No Apparent Injury

☐ Minor Injury

☐ Serious Injury - Fracture, dislocation, traumatic brain injury (concussion), laceration requiring sutures or staples (or Dermabond used in place of sutures), torn ligaments, 2nd and 3rd degree burns, loss of consciousness, sprain or strain (if moderate or severe). Other injuries may also be considered to be serious based on severity, location on the body, etc.

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☐ **Sent Page 1 to: DIDD** **E-mail - DIDD.Incidentmgmt@tn.gov** **(Fax – 877-551-5591)** Date/Time: / / @ : **AM ☐ PM ☐**

➢ **Incident Review Committee summary** **Date:** / /

Discussion Issues (Include review of staff actions in response, current status of person served, possible corrective/preventive actions)

Management Actions

Action Taken	Person Responsible	Expected Completion Date	Follow-up
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Incident Management Coordinator

PRINT NAME/TITLE _____ ,

SIGNATURE _____

DATE/TIME / / @ : **AM ☐ PM ☐**