HFL&C INCIDENT REPORT (SFY 2010) Case #:

SECTION 1 – CONSUMER INFORMATION

Name of Consumer	First:	Middle:	Last:
Social Security #		Gender: ☐ Male ☐ Female	DOB
Residence Address	Street Address:	City: Zip:	Phone:

Consumer Competency Level	ADLs (Resident Needs Assistance With) Check All That Apply
☐ High ☐ Moderate Low	☐ Walking ☐ Wheelchair ☐ Bathing ☐ Eating ☐ Transfer ☐ Total Care ☐ None Verbal ☐ Yes ☐ No

Diagnosis(es):

Name of Doctor & Phone #:

SECTION 2 – DESCRIPTION OF INCIDENT *(Staff person with the most direct knowledge of incident fills out this section.)*

TYPE OF ALLEGED INCIDENT

☐ **Abuse** ☐ **Neglect** ☐ **Exploitation** ☐ **Injuries of Unknown Origin**

Person responsible for individual's care at time of incident:

Has this happened before? ☐ Yes ☐ No

Was anyone else present at the time of the incident: ☐ Yes ☐ No If Yes, Identify below:

Name:	Title or Relationship:	Phone:
Name:	Title or Relationship:	Phone:

Date Incident Occurred:	**Time:**	☐ AM ☐ PM ☐ Unknown

Before the Incident:

During the Incident:

DOH-HFL&C FAX (888-576-0012) e-mail: incident.management@state.nm.us

When faxing information that is not on this form please label it with resident's name and incident date.

Name of Consumer	First:	Middle:	Last:	SSN: - -	Date of Incident:

After the Incident:

Person Completing Sections 1& 2

Confidentiality Desired: ☐ Yes ☐ No	Name:	Agency:	Title/Relationship:	Phone:	Date Completed:	Time Completed

SECTION 3 – AGENCY / FACILITY INFORMATION

Reporting Agency:			Incident Coordinator:	
Address:	City:	Zip:	County:	Phone:

SECTION 4 – ADMINISTRATIVE INFORMATION *Check the applicable box(s) below:

☐ ICFMR ☐ Diagnostic & Treatment Facility ☐ Limited Diagnostic & Treatment Facility ☐ Specialty Hospital

☐ Adult Residential Care Facility ☐ Home Health ☐ Hospice ☐ Nursing Facility ☐ Other

INITIAL ACTIONS TAKEN BY THE AGENCY/FACILITY TO ASSURE HEALTH & SAFETY:

PLANS FOR FURTHER ACTIONS IN RESPONSE TO THE INCIDENT:

SECTION 5 – NOTIFICATIONS

Always notify DOH/DHI within 24 hours via FAX: (888-576-0012) or e-mail: incident.management@state.nm.us

Legal Guardian ☐ None ☐ Notified	Guardian Name & Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:		State:	Zip:
Other ☐ None ☐ Notified	Name & Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:		State:	Zip:

Person Completing Sections 3, 4 & 5:

Name:	Title/Relationship:	Phone:	Date Completed:	Time Completed:

By typing your name below you are effectively signing this document. Your typed name is acceptable as a replacement for your written signature.

Name: Date:

OPTIONAL INFORMATION

(If choosing to file this page, it is due within 72 hours of initial report. This page is NOT required.)

Name of Consumer	First:	Middle:	Last:	SSN: - -	Date of Incident

SECTION 6 – ADDITIONAL INFORMATION **Information to be provided in cases of medical emergency services.**

☐YES☐NO Hospital Admission Required? If Yes/Discharge Date:

☐YES☐NO Medical Records FAXED to DHI on (Date):

☐YES☐NO Diagnosis(es) given at Emergency Intervention:

Comments:

Does this consumer have an existing medical diagnosis that may impact the reported incident?

☐ YES ☐ NO If yes, provide DX:

If this report involves abuse, neglect or exploitation & the responsible provider wishes to confirm that a person in our employ has committed the alleged event, check the appropriate box, then sign and date at the bottom of this page:

☐ Abuse ☐ Neglect ☐ Financial Exploitation

What measures have been put in place to remedy the situation and to ensure the health and safety of the consumer?

Additional Information that may be pertinent to this incident?

Authorized by:	Last Name:	First Name:	Title:	Agency:

DOH-HFL&C FAX (800) 584-6057 e-mail: incident.management@state.nm.us
When faxing information that is not on this form please label it with consumer's name and incident date.