

HFL&C INCIDENT REPORT (SFY 2011)

Fields in red are required

SECTION 1 – CONSUMER INFORMATION

Name of Consumer	First:	Middle:	Last:
Social Security #	Gender	Male	Female
Residence Address	Street Address:	City:	Zip:
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 Consumer's Doctor: _____ **Doctor's 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
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Person responsible for individual's care at time of incident:

Name: _____ Title: _____ Phone: _____

Has this happenYd 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 Of Incident: _____ **Time Of Incident:** _____ **AM** **PM** **Unknown**

Describe what you saw and/or what you heard in order of occurrence:

Before the Incident:

During the Incident:

After the Incident:

Person Completing Sections 1 & 2

Confidentiality Name Desired:	Agency:	Title/Relationship:	Phone:	Date Completed:	Time Completed:
YES NO					

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

SECTION 3 – AGENCY / FACILITY INFORMATION

Reporting Agency: Incident Coordinator:

Address: City: Zip: County: Phone:
Select County

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 email: incident.management@state.nm.us

Legal Guardian Guardian Name: Date: Time: Person Making Contact:
None Street Address: City: State: Zip: Phone:
Notified Select State

Other Name: Date: Time: Person Making Contact:
None Street Address: City: State: Zip: Phone:
Notified Select State

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:

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 BUa Y. H]hY. 5[YbVth