

New Mexico Department of Health
Community Based
INCIDENT REPORT (SFY 2010)

DOH/DHI Use Only
Case #:**SECTION 1 – CONSUMER INFORMATION**

Name of Consumer	*First:	Middle:	*Last:		
Social Security #	- -	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		*DOB:	
Residence Address	*Street Address:		*City:	*Zip:	*Phone:
*Consumer Competency Level: <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low		*ADLs (Consumer Needs Assistance With) Check All That Apply: <input type="checkbox"/> Walking <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bathing <input type="checkbox"/> Eating <input type="checkbox"/> Transfer <input type="checkbox"/> Total Care <input type="checkbox"/> None Verbal: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Diagnosis(es):

Name of Doctor & Phone #:

List Consumer's Current Medications or Attach Medication Administration Record (MAR):

SECTION 2 – DESCRIPTION OF INCIDENT**(Staff person with the most direct knowledge of incident fills out this section.)*****TYPE OF ALLEGED INCIDENT****Reminder:** Abuse, Neglect and Exploitation must be reported to APS via Fax (505) 476-4913 or Phone (866) 654-3219 **ABUSE** **NEGLECT** **EXPLOITATION**
 Natural/Expected Death Unexpected Death
 Emergency Services Law Enforcement Involvement Environmental Hazard

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

Name: _____ Title: _____ Phone: _____

If this person is employed by a provider agency, which agency:

Has this happened before? Yes No Was provider notified of incident? Yes NoWere other consumers/individuals present? Yes No If Yes, Other Consumer's Initials: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

*Location of Incident:

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 and 2

*Confidentiality Desired <input type="checkbox"/> Yes <input type="checkbox"/> No	*Name:	*Agency:	*Title/Relationship:	*Phone:	*Date Completed:	*Time Completed:
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DOH Fax (800) 584-6057 email: incident.management@state.nm.us

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

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Consumer Information	First Name:	Middle:	Last Name:	SSN:	Date of Incident:
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SECTION 3 – AGENCY INFORMATION

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

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

DD Waiver [If DD, check Jackson Yes No]
 D&E Waiver (CoLTS C)
 Medically Fragile Waiver
 ICF-MR (Jackson)
 DD/State General Fund
 Family/Infant/Toddler
 TBI
 Other

DD Programs ONLY - Type of residential services received by the consumer:
 Supported Living
 Family Living
 Independent Living
 None

Initial actions taken by the agency to assure health and safety:

Was law enforcement contacted? Yes No Is the consumer still with the agency? Yes No

Plans for further actions in response to the incident:

SECTION 5 – NOTIFICATIONS TO AGENCIES REQUIRED

Always notify DOH/DHI within 24 hours of the incident via FAX: (800) 584-6057
Or email: incident.management@state.nm.us

Notify Adult Protective Services(APS)/Child Protective Services (CPS) to report Abuse, Neglect or Exploitation ONLY
CPS Fax: (505) 841-6691 APS Fax: (505) 476-4913 or Phone APS: (866) 654-3219
Name of Person Phoned:

Legal Guardian <input type="checkbox"/> None <input type="checkbox"/> Notified	Guardian Name and Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:	State:	Zip:	

Independent Case Manager <input type="checkbox"/> None <input type="checkbox"/> Notified	Case Management Agency Name:			Person Making Contact:	
	Case Manager Name and Phone #:			Date:	Time:
	Street Address:	City:	State:	Zip:	

Other <input type="checkbox"/> None <input type="checkbox"/> Notified	Name and Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:	State:	Zip:	

Person Completing Sections 3, 4 and 5

*Name:	*Title/Relationship:	*Phone:	*Date Completed:	*Time Completed:
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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:
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SECTION 6 - OPTIONAL INFORMATION (If choosing to file this page, it is due within 72 hours of initial report. This page is NOT required.)					
Consumer Information	First Name:	Middle:	Last Name:	SSN:	Date of Incident:
Hospital admission required: <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, discharge date:		
Medical Records FAXED to DHI: <input type="checkbox"/> Yes <input type="checkbox"/> No			Date faxed:		
Diagnosis(es) given at emergency intervention: <input type="checkbox"/> Yes <input type="checkbox"/> No			List Diagnosis(es)		
Comments:					
Does this consumer have an existing medical diagnosis (es) that may impact the reported incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide diagnosis(es):					
If this report involves abuse, neglect or exploitation and the responsible provider wants to confirm that a person in your employ has committed the alleged event, check the appropriate box, then sign and date at the bottom of this page:					
<input type="checkbox"/> ABUSE		<input type="checkbox"/> NEGLECT		<input type="checkbox"/> EXPLOITATION	
The following 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 Fax (800) 584-6057 email: incident.management@state.nm.us
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