

**Commonwealth of Massachusetts - Department of Developmental Services
Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT**

(* = *MANDATORY FIELD*)

Initial Report: Individual Information

*** (1) Individual**

First Name: [Click here to enter text.](#) **Last Name:** [Click here to enter text.](#)

*** (2) Individual's Service Coordinator:** [Click here to enter text.](#)

*** (3A) Is the individual subject to a Day Level II or Level III Behavior Plan?** Yes No

*** (3B) Is the individual subject to a Res. Level II or Level III Behavior Plan?** Yes No

*** (4) Home Address:** [Insert Street Name](#) [City](#) [State](#) [Zip](#)

Initial Report: Filing Agency Information

*** (5) Filing Agency:** [Click here to enter text.](#)

*** (6) Staff filling out Paper Incident Report:** [Click here to enter text.](#)

(7) Staff Responsible for Incident Follow-up: [Click here to enter text.](#)

Initial Report: Incident Classification

*** (8A) Date Incident Discovered:** [Click here to enter a date.](#)

*** (8B) Approximate Time Incident Discovered:** [Click here to enter text.](#) AM/PM

*** (9) Do you know the date and/or approximate time that the incident occurred?**

CHECK ONE Both Date Only Time Only Neither

Complete only if known

(9A) Date Incident Occurred: [Click here to enter a date.](#)

(9B) Approximate Time Incident Occurred: [Click here to enter text.](#) AM/PM

*** (10) Did staff directly observe the incident?** Yes No Unknown

*** (11) Who was responsible for the supervision of the individual at the time of the incident?**

Choose one from the following:

- | | |
|---|---|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Other Provider |
| <input type="checkbox"/> Family | <input type="checkbox"/> Other |
| <input type="checkbox"/> Reporting Provider | <input type="checkbox"/> Unknown |

(12) If Reporting Provider, was supervision at the time of the incident being provided as assigned?

Yes No Unknown

(13) Responsible Site: [Click here to enter text.](#)

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#)

Last Name: [Click here to enter text.](#)

***(14) Incident Categories: CHECK ONE**

(**INDICATES MAJOR LEVEL OF REVIEW REQUIRED)

- (1) Unexpected/Suspicious Death
 - Accidental**
 - Suicide**
 - Unusual Circumstances**
 - Other Unexpected/Sudden Death**
- (2) Suicide Attempt
 - First Known Attempt**
 - Repeat Attempt**
- (3) Unexpected Hospital Visit (*must complete #36-44*)
 - Medical Hospitalization
 - Psychiatric Hospitalization
 - E.R. Visit
 - Emergency Psychiatric Services Evaluation
- (4) Inappropriate Sexual Behavior
 - Aggressive Sexual Behavior Alleged Victim**
 - Aggressive Sexual Behavior Alleged Perpetrator**
 - Sexual Misbehavior Alleged Victim
 - Sexual Misbehavior Alleged Perpetrator
- (5) Victim of Physical Altercation
- (6) Significant Behavioral Incident
 - Involving a Physical Altercation
 - Not Involving a Physical Altercation
- (7) Missing Person
 - Law Enforcement Contacted**
 - Law Enforcement Not Contacted
- (8) Medical Intervention Not Requiring a Hospital Visit
 - Medical
 - Psychiatric
- (9) Fire
 - Known Origin – Allegedly Started by Individual
 - Known Origin – Not Started by Individual
 - Source Unknown
- (10) Suspected Mistreatment
 - Alleged Victim of Psychological Abuse
 - Alleged Victim of Verbal Abuse
 - Alleged Victim of Physical Abuse
 - Alleged Omission – Failure to Provide Needed Supports
 - Alleged Omission – Failure to Provide Needed Supervision
- (11) Property Damage
 - Alleged Victim
 - Alleged Perpetrator
- (12) Theft
 - Alleged Victim
 - Alleged Perpetrator**
- (13) Other Criminal Activity
 - Alleged Victim**
 - Alleged Perpetrator**
- (14) Transportation Accident
 - Pedestrian
 - Motor Vehicle
 - Other
- (15) Emergency Relocation
- (16) Unplanned Transportation Restraint
- (17) Other

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

***(15A) Did the incident involve the ingestion of non-food substances?**

Yes No Unknown

***(15B) Did the incident involve unauthorized use of drugs/alcohol?** Yes No

***(15C) Did the incident involve suicidal threat/ideation?** Yes No

***(15D) Did the incident involve non-compliance with a medical directive?** Yes No

***(15E) Did the incident involve a medication refusal?** Yes No

ONLY COMPLETE QUESTIONS #16-#18 FOR SIGNIFICANT BEHAVIORAL INCIDENTS INVOLVING A PHYSICAL ALTERCATION. OTHERWISE, SKIP TO #19.

(16) Did the incident involve an altercation towards: *CHECK ALL THAT APPLY*

Another Individual Staff Other

(17) Did the altercation result in an injury? *CHECK ONE*

Yes-Medical Treatment Needed
 Yes-Medical Treatment Not Needed
 No

(18) Where did the altercation take place? *CHECK ONE*

Within the program site In the community

Description of Any Injury Associated with the Incident:

***(19) Is there an injury to the individual?** Yes No

IF YES, COMPLETE QUESTIONS #19-#23. IF NO, SKIP TO #24.

(20) Cause of Injury: *CHECK ALL THAT APPLY*

<input type="checkbox"/> Inflicted by self	<input type="checkbox"/> Fall	<input type="checkbox"/> Insect/Animal Bite
<input type="checkbox"/> Inflicted by staff	<input type="checkbox"/> Equipment	<input type="checkbox"/> Motor Vehicle
<input type="checkbox"/> Inflicted by peer	<input type="checkbox"/> Restraint-Related	<input type="checkbox"/> Seizure
<input type="checkbox"/> Inflicted by other	<input type="checkbox"/> Transfer/Handling	<input type="checkbox"/> Other
<input type="checkbox"/> Environmental	<input type="checkbox"/> PICA/Eating Non-food items	<input type="checkbox"/> Unknown

(20A) If Other, Specify: [Click here to enter text.](#)

(21) Briefly Describe the Injury Including Cause and Factors: [Click here to enter text.](#)

(22) Type of Injury: *CHECK ALL THAT APPLY*

<input type="checkbox"/> Abrasion/Cut	<input type="checkbox"/> Burn	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Poison
<input type="checkbox"/> Bite	<input type="checkbox"/> Choking	<input type="checkbox"/> Internal Injury	<input type="checkbox"/> Puncture
<input type="checkbox"/> Bruise	<input type="checkbox"/> Fracture	<input type="checkbox"/> Other	<input type="checkbox"/> Sprain/Strain

(22A) If Other, Specify: [Click here to enter text.](#)

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

(23) Body Part Affected by Injury: CHECK ALL THAT APPLY

- | | | | |
|-----------------------------------|---|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Toe | <input type="checkbox"/> Front Torso | <input type="checkbox"/> Eye | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Foot | <input type="checkbox"/> Back Torso | <input type="checkbox"/> Nose | <input type="checkbox"/> Hand |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Internal
Organs | <input type="checkbox"/> Ear | <input type="checkbox"/> Finger |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Neck | <input type="checkbox"/> Mouth | <input type="checkbox"/> Other |
| <input type="checkbox"/> Leg | <input type="checkbox"/> Head | <input type="checkbox"/> Shoulder | |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Face | <input type="checkbox"/> Arm | |
| <input type="checkbox"/> Genitals | | <input type="checkbox"/> Elbow | |

(23A) If Other Specify: [Click here to enter text.](#)

Initial Report: Incident Description I

***(24) Incident Description:** Describe in detail exactly what happened during the incident. Include dates, times, and all people involved including staff. Include all relevant details prior to, during, and after the incident.

[Click here to enter text.](#)

Initial Report: Incident Description II

***(25) What is the most recent status of the individual? [Click here to enter text.](#)**

***(26) Is the Incident Location known?** Yes No

(26A) Where did the incident occur? CHECK ONE

- | | | |
|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Individual's Residence | <input type="checkbox"/> Day Service | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Family Residence | <input type="checkbox"/> Work Site | <input type="checkbox"/> Vehicle |
| <input type="checkbox"/> Residential Setting-Other | <input type="checkbox"/> School | <input type="checkbox"/> Other |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Community | <input type="checkbox"/> Unknown |

(26B) Location Detail: CHECK ONE

- Bedroom
- Dining Area
- Living Area
- Kitchen
- Bathroom
- Common Area
- Public Area
- Laundry Area
- Stairs or Stairwells
- Basement
- Yard
- Work Area
- Vehicle
- Outdoor Area
- Other

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

(26C) Site Location of Incident (address): [Click here to enter text.](#)

(26D) IF NOT AT PROVIDER SITE, INFORMATION ABOUT INCIDENT LOCATION:

Location Name/Description: [Click here to enter text.](#)

Location Name and address, if any: [Click here to enter text.](#)

Initial Report: Actions Taken To Protect Health, Safety, and Rights

***(27) Actions Taken to Protect Health, Safety and Rights:** *Immediate actions taken to protect the individual. Describe administrative, health/safety, treatment and other actions taken to address the incident to date.*
[Click here to enter text.](#)

(28) Treatment Provided By: *CHECK ALL THAT APPLY*

- Self/Family
- Staff (non licensed)
- LPN, RN, NP
- EMT
- MD's Office
- ER/Crisis Team (no admission)
- PCA
- Other (*describe above*)
- None

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#)

Last Name: [Click here to enter text.](#)

Initial Report: Involved Parties

***(29) People Involved with Incident:** (ADD ADDITIONAL SHEETS AS NEEDED)

	*(29B) Involvement <i>SELECT ALL THAT APPLY</i>	*(29C) Relationship <i>SELECT ALL THAT APPLY</i>
(29A) Involved Party Name: Click here to enter text.	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider <input type="checkbox"/> Volunteer Staff <input type="checkbox"/> General Public <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> Other <input type="checkbox"/> Friend
(29D) Telephone: Click here to enter text.		
Involved Party Name: Click here to enter text.	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider <input type="checkbox"/> Volunteer Staff <input type="checkbox"/> General Public <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> Other <input type="checkbox"/> Friend
Telephone: Click here to enter text.		
Involved Party Name: Click here to enter text.	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider <input type="checkbox"/> Volunteer Staff <input type="checkbox"/> General Public <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> Other <input type="checkbox"/> Friend
Telephone: Click here to enter text.		
Involved Party Name: Click here to enter text.	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider <input type="checkbox"/> Volunteer Staff <input type="checkbox"/> General Public <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> Other <input type="checkbox"/> Friend
Telephone: Click here to enter text.		
Involved Party Name: Click here to enter text.	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider <input type="checkbox"/> Volunteer Staff <input type="checkbox"/> General Public <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> Other <input type="checkbox"/> Friend
Telephone: Click here to enter text.		

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

Initial Report: Notification

***(30A) Was the On-Call person notified?** Yes No

***(30B) Name of On-Call person:** [Click here to enter text.](#)

***(31A) Has Executive Office of Elder Affairs been notified?** (Only applies to individuals greater than 59 years old.
Choose 'N/A' for all other individuals.) Yes-Have Notified No-Will Notify No N/A

***(31B) Has DPPC Been Notified?** Yes-Have Notified No-Will Notify No

***(31C) Has DCF Been Notified?** Yes-Have Notified No-Will Notify No N/A

(32) Has Family/Guardian Been Notified? Yes-Have Notified No-Will Notify No N/A

***(33) Was Law Enforcement Involved?** Yes No Unknown

***(34A) Signature of the Staff filling out Paper Incident Report:** _____

***(34B) Position:** [Click here to enter text.](#)

***(34C) Telephone:** [Click here to enter text.](#)

***(34D) Date/Time of Report:** [Click here to enter a date.](#) [Click here to enter a time](#)

***(35A) Name of Supervisor:** [Click here to enter text.](#)

***(35B) Position:** [Click here to enter text.](#)

***(35C) Signature of Supervisor:** _____

(35D) Telephone: [Click here to enter text.](#)

(35E) Date/Time of Review: [Click here to enter a date.](#) [Enter Time](#)

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

Final Report: HOSPITAL VISIT (Complete Only for a Hospital Visit)

(36) Length of Time spent in ER/Urgent Care/Crisis Unit

<6 Hours 6-12 Hours 12-24 Hours >24 Hours Unknown

(37) Admission Information: *IF NOT ADMITTED, SKIP TO QUESTION #39*

(37A) Date of Admission: [Click here to enter a date.](#)

(37B) Hospital Name: [Click here to enter text.](#)

***(37C) Reason for ER/Hospital Visit:**

- | | |
|--|---|
| <input type="checkbox"/> Near Drowning | <input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supervision** |
| <input type="checkbox"/> Inappropriate Sexual Behavior | Property Damage |
| <input type="checkbox"/> Aggressive Sexual Behavior Alleged Victim** | <input type="checkbox"/> Alleged Victim |
| <input type="checkbox"/> Aggressive Sexual Behavior Alleged Perpetrator** | <input type="checkbox"/> Alleged Perpetrator |
| <input type="checkbox"/> Sexual Misbehavior Alleged Victim | Theft |
| <input type="checkbox"/> Sexual Misbehavior Alleged Perpetrator | <input type="checkbox"/> Alleged Victim |
| <input type="checkbox"/> Victim of Physical Altercation ** | <input type="checkbox"/> Alleged Perpetrator |
| Significant Behavioral Incident | Other Criminal Activity |
| <input type="checkbox"/> Involving a Physical Altercation ** | <input type="checkbox"/> Alleged Victim** |
| <input type="checkbox"/> Not Involving a Physical Altercation ** | <input type="checkbox"/> Alleged Perpetrator** |
| Missing Person | Transportation Accident |
| <input type="checkbox"/> Law Enforcement Contacted** | <input type="checkbox"/> Pedestrian |
| <input type="checkbox"/> Law Enforcement Not Contacted | <input type="checkbox"/> Motor Vehicle |
| Fire | <input type="checkbox"/> Other |
| <input type="checkbox"/> Known Origin – Allegedly Started by Individual** | <input type="checkbox"/> Emergency Relocation |
| <input type="checkbox"/> Known Origin – Not Started by Individual** | <input type="checkbox"/> Unplanned Transportation Restraint |
| <input type="checkbox"/> Source Unknown** | <input type="checkbox"/> Illness <input type="checkbox"/> Fire of Unknown Origin |
| Suspected Mistreatment | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Alleged Victim of Psychological Abuse** | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alleged Victim of Verbal Abuse** | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Alleged Victim of Physical Abuse** | |
| <input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supports** | |

(38) If admitted, was the admission from the ER? Yes No

(39A) If individual went to the ER, did you contact the individual's doctor's office prior to going to the ER? Yes No Unknown

(39B) If yes, did you get an appointment at the doctor's office?

Yes No Unknown

(39C) If no, reason for no appointment at doctor's office: Dr. appointment not available
 Dr. recommended ER visit due to severity
 Unknown

(40) What Occurred During the Hospital Visit? CHECK ALL THAT APPLY

- Death Surgical Procedure Admission to ICU/CCU Psychiatric Admission
 None of the Above

(40A) If other, please specify: [Click here to enter text.](#)

(41) Discharge Information: *IF NOT DISCHARGED, SKIP TO QUESTION #45*

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

(41A) Actual Date of Discharge: [Click here to enter a date.](#)

(41B) ER/Crisis Unit/hospital discharge diagnosis:

SEE APPENDIX in INCIDENT REPORT INSTRUCTIONS

Discharge Diagnosis 1: [Click here to enter text.](#)

Discharge Diagnosis 2: [Click here to enter text.](#)

Discharge Diagnosis 3: [Click here to enter text.](#)

(41C) If Other was chosen as a discharge diagnosis, please specify: [Click here to enter text.](#)

(41D) Did you get instructions Upon Discharge? Yes No

(41E) What changed for this person upon discharge? *CHECK ALL THAT APPLY*

- | | |
|--|---|
| <input type="checkbox"/> Increase in medication(s) (compared to medications before admission) | <input type="checkbox"/> Instructions on when to contact the health care practitioner |
| <input type="checkbox"/> Decrease in medication(s)/Discontinuation of medication(s) (compared to medications before admission) | <input type="checkbox"/> Wound care |
| <input type="checkbox"/> New medication | <input type="checkbox"/> New equipment |
| <input type="checkbox"/> New treatment | <input type="checkbox"/> Newly diagnosed condition |
| <input type="checkbox"/> New instructions received for signs and symptoms | <input type="checkbox"/> New living situation (specify in additional information below) |
| | <input type="checkbox"/> Transferred to rehabilitation or nursing facility |
| | <input type="checkbox"/> No change |

(42) Current Status: *CHECK ALL THAT APPLY*

- Change in daily living capabilities – lower than before hospitalization
- Change in daily living capabilities – higher than before hospitalization
- No change in daily living capabilities
- New Health status – temporary condition that will get better
- New Health status – progressively deteriorating condition
- New Health status – permanent condition, not changing
- New Health status – terminal condition
- Unclear at this time

(43) Specify any follow up appointments scheduled with a health care professional: *CHECK ALL THAT APPLY*

- | | |
|---|--|
| <input type="checkbox"/> Primary Care Physician (PCP) | <input type="checkbox"/> Outpatient Psychiatrist |
| <input type="checkbox"/> Admitting Physician | <input type="checkbox"/> Admitting Psychiatrist |
| <input type="checkbox"/> Surgeon | <input type="checkbox"/> Other (specify in additional information below) |
| <input type="checkbox"/> Specialist | <input type="checkbox"/> None |

(44) Any Additional/Clarifying Information: [Click here to enter text.](#)

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

Final Report: Additional Information

***(45) Incident Description:** *Any updated or corrected information from the Incident Description (Question 24) including dates, times, people involved, and relevant details prior to, during, and after the incident. Indicate the current status of the individual. If law enforcement has been contacted please list details of actions taken by law enforcement.*

[Click here to enter text.](#)

Final Report: Action Steps

***(46) Are there Additional Action Steps for this Incident:** Yes No Unknown

(46A) Action Step:	(46B) Targeted Completion Date: (MM/DD/YYYY)	(46C) Responsible Party: (Name and/or Position)
Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter a date.	Click here to enter text.
Click here to enter text.	Click here to enter a date.	Click here to enter text.

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

Final Report: Involved Parties

(47) People Involved with Incident:

CORRECT ONLY IF THERE ARE CHANGES FROM THE INITIAL REPORT. ADD ADDITIONAL SHEETS AS NEEDED

	*(47B) Involvement <i>SELECT ALL THAT APPLY</i>	*(47C) Relationship <i>SELECT ALL THAT APPLY</i>
(47A) Involved Party Name: Click here to enter text.	<input type="checkbox"/> Eyewitness to Incident <input checked="" type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider <input type="checkbox"/> Volunteer Staff <input type="checkbox"/> General Public <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> Other <input type="checkbox"/> Friend
(47D) Telephone: Click here to enter text.		
Involved Party Name: Click here to enter text.	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider <input type="checkbox"/> Volunteer Staff <input type="checkbox"/> General Public <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> Other <input type="checkbox"/> Friend
Telephone: Click here to enter text.		
Involved Party Name: Click here to enter text.	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider <input type="checkbox"/> Volunteer Staff <input type="checkbox"/> General Public <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> Other <input type="checkbox"/> Friend
Telephone: Click here to enter text.		

Final Report: Verification of Time and Categorization

***(48) Initial Report Information is correct to the best of my knowledge:**

- Yes, *IF YES, SKIP TO # 69A.*
 No, *IF NO, DESCRIBE ANY UPDATED OR CORRECTED INFORMATION BELOW AND ANSWER ALL APPLICABLE QUESTIONS:*

***(49A) Date Incident Discovered: [Click here to enter a date.](#)**

***(49B) Approximate Time Incident Discovered: [Click here to enter time.](#)**

HH:MM AM/PM

***(50) Do you know the date and/or approximate time that the incident occurred:**

- Both Date Only Time Only Neither

(50A) Date Incident Occurred: [Click here to enter a date.](#)

(50B) Approximate Time Incident Occurred: [Click here to enter time.](#)

HH:MM AM/PM

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#)

Last Name: [Click here to enter text.](#)

***(51) Incident Categories: CHECK ONE (**INDICATES MAJOR LEVEL OF REVIEW REQUIRED)**

- | | |
|---|--|
| <p>Unexpected/Suspicious Death</p> <ul style="list-style-type: none"><input type="checkbox"/> Accidental**<input checked="" type="checkbox"/> Suicide**<input type="checkbox"/> Unusual Circumstances**<input type="checkbox"/> Other Unexpected/Sudden Death** <p>(2) Suicide Attempt</p> <ul style="list-style-type: none"><input type="checkbox"/> First Known Attempt**<input type="checkbox"/> Repeat Attempt** <p>(3) Unexpected Hospital Visit (<i>must complete Page #7</i>)</p> <ul style="list-style-type: none"><input type="checkbox"/> Medical Hospitalization<input type="checkbox"/> Psychiatric Hospitalization<input type="checkbox"/> E.R. Visit<input type="checkbox"/> Emergency Psychiatric Services Evaluation <p>(4) Inappropriate Sexual Behavior</p> <ul style="list-style-type: none"><input type="checkbox"/> Aggressive Sexual Behavior Alleged Victim**<input type="checkbox"/> Aggressive Sexual Behavior Alleged Perpetrator**<input type="checkbox"/> Sexual Misbehavior Alleged Victim<input type="checkbox"/> Sexual Misbehavior Alleged Perpetrator <p>(5) <input type="checkbox"/> Victim of Physical Altercation</p> <p>(6) Significant Behavioral Incident</p> <ul style="list-style-type: none"><input type="checkbox"/> Involving a Physical Altercation<input type="checkbox"/> Not Involving a Physical Altercation <p>(7) Missing Person</p> <ul style="list-style-type: none"><input type="checkbox"/> Law Enforcement Contacted**<input type="checkbox"/> Law Enforcement Not Contacted <p>(8) Medical Intervention Not Requiring a Hospital Visit</p> <ul style="list-style-type: none"><input type="checkbox"/> Medical<input type="checkbox"/> Psychiatric | <p>(9) Fire</p> <ul style="list-style-type: none"><input type="checkbox"/> Known Origin – Allegedly Started by Individual<input type="checkbox"/> Known Origin – Not Started by Individual<input type="checkbox"/> Source Unknown <p>(10) Suspected Mistreatment</p> <ul style="list-style-type: none"><input type="checkbox"/> Alleged Victim of Psychological Abuse<input type="checkbox"/> Alleged Victim of Verbal Abuse<input type="checkbox"/> Alleged Victim of Physical Abuse<input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supports<input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supervision <p>(11) Property Damage</p> <ul style="list-style-type: none"><input type="checkbox"/> Alleged Victim<input type="checkbox"/> Alleged Perpetrator <p>(12) Theft</p> <ul style="list-style-type: none"><input type="checkbox"/> Alleged Victim<input type="checkbox"/> Alleged Perpetrator** <p>(13) Other Criminal Activity</p> <ul style="list-style-type: none"><input type="checkbox"/> Alleged Victim**<input type="checkbox"/> Alleged Perpetrator** <p>(14) Transportation Accident</p> <ul style="list-style-type: none"><input type="checkbox"/> Pedestrian<input type="checkbox"/> Motor Vehicle<input type="checkbox"/> Other <p>(15) <input type="checkbox"/> Emergency Relocation</p> <p>(16) <input type="checkbox"/> Unplanned Transportation Restraint</p> <p>(17) <input type="checkbox"/> Other</p> |
|---|--|

***(52) Staff filling out Paper Final Report: [Click here to enter text.](#)**

***(53) Did staff directly observe the incident?** Yes No Unknown

***(54) Who was responsible for the supervision of the individual at the time of the incident?**

Choose one from the following:

- | | |
|---|---|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Other Provider |
| <input type="checkbox"/> Family | <input type="checkbox"/> Other |
| <input type="checkbox"/> Reporting Provider | <input type="checkbox"/> Unknown |

(55) If Reporting Provider, was supervision at the time of the incident being provided as assigned?

Yes No

***(56A) Was the On-Call person notified:** Yes-Have Notified No-Will Notify No

(56B) Name of On-Call person notified: [Click here to enter text.](#)

***(57A) Has Executive Office of Elder Affairs been notified?**

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

Yes-Have Notified No-Will Notify No N/A

(Only applies to individuals greater than 59 years old. Choose N/A of all other individuals)

- *(57B) Has DPPC Been Notified?** Yes-Have Notified No-Will Notify No
- *(57C) Has DCF Been Notified?** Yes-Have Notified No-Will Notify No N/A
- (58) Has Family/Guardian Been Notified?** Yes-Have Notified No-Will Notify No N/A
- *(59) Was Law Enforcement Involved?** Yes No Unknown
- *(60A) Did the incident involve the ingestion of non-food substances?** Yes No Unknown
- *(60B) Did the incident involve unauthorized use of drugs/alcohol?** Yes No
- *(60C) Did the incident involve suicidal threat/ideation?** Yes No
- *(60D) Did the incident involve non-compliance with a medical directive?** Yes No
- *(60E) Did the incident involve a medication refusal?** Yes No

ONLY COMPLETE QUESTIONS #61-#63 FOR SIGNIFICANT BEHAVIORAL INCIDENTS INVOLVING A PHYSICAL ALTERCATION. OTHERWISE, SKIP TO #64.

(61) Did the incident involve towards: *CHECK ALL THAT APPLY*

Another Individual Staff Other

(62) Did the altercation result in an injury? *CHECK ONE*

Yes-Medical Treatment Needed Yes-Medical Treatment Not Needed No

(63) Where did the altercation take place? *CHECK ONE*

Within the program site In the community

Description of Any Injury Associated with the Incident:

***(64) Is there an injury to the individual?** Yes No

IF YES, COMPLETE QUESTIONS #65-#68. IF NO, SKIP TO #69.

(65) Cause of Injury: *CHECK ALL THAT APPLY*

<input type="checkbox"/> Inflicted by self	<input type="checkbox"/> Fall	<input type="checkbox"/> Insect/Animal Bite
<input type="checkbox"/> Inflicted by staff	<input type="checkbox"/> Equipment	<input type="checkbox"/> Motor Vehicle
<input type="checkbox"/> Inflicted by peer	<input type="checkbox"/> Restraint-Related	<input type="checkbox"/> Seizure
<input type="checkbox"/> Inflicted by other	<input type="checkbox"/> Transfer/Handling	<input type="checkbox"/> Other
<input type="checkbox"/> Environmental	<input type="checkbox"/> PICA/Eating Non-food items	<input type="checkbox"/> Unknown

(65A) If Other, Specify: [Click here to enter text.](#)

(66) Briefly Describe the Injury Including Cause and Factors: [Click here to enter text.](#)

(67) Type of Injury: *CHECK ALL THAT APPLY*

<input type="checkbox"/> Abrasion/Cut	<input type="checkbox"/> Burn	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Poison
<input type="checkbox"/> Bite	<input type="checkbox"/> Choking	<input type="checkbox"/> Internal Injury	<input type="checkbox"/> Puncture
<input type="checkbox"/> Bruise	<input type="checkbox"/> Fracture	<input type="checkbox"/> Other	<input type="checkbox"/> Sprain/Strain

(67A) If Other, Specify: [Click here to enter text.](#)

(68) Body Part Affected by Injury: *CHECK ALL THAT APPLY*

**Massachusetts Department of Developmental Services and Massachusetts
Rehabilitation Commission
Incident Report - INITIAL REPORT (continued)**

Individual: First Name: [Click here to enter text.](#)

Last Name: [Click here to enter text.](#)

- Toe
- Foot
- Ankle
- Knee
- Leg
- Hip
- Genitals
- Front Torso
- Back Torso
- Internal Organs
- Neck
- Head
- Face
- Eye
- Nose
- Ear
- Mouth
- Shoulder
- Arm
- Elbow
- Wrist
- Hand
- Finger
- Other

(68A) If Other Specify: [Click here to enter text.](#)

**Massachusetts Department of Developmental Services and Massachusetts Rehabilitation
Commission**

Incident Report - INITIAL REPORT (continued)

Individual: First Name: [Click here to enter text.](#) Last Name: [Click here to enter text.](#)

Final Report – Finalization

***(69A) Name of Person Finalizing Report:** [Click here to enter text.](#)

***(69B) Position:** [Click here to enter text.](#)

***(69C) Signature:** _____

(69D) Telephone: [Click here to enter text.](#)

(69E) Date/Time of Review: [Click here to enter a date.](#) [Click here to enter time.](#)