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

(* = MANDATORY FIELD)

Initial Report: Individual Information

***(1)** Individual: First Name _____ Last Name _____

***(2)** Individual's Service Coordinator: _____

***(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: _____ _____ _____
(4A) Street **(4B)** City **(4C)** State

Initial Report: Filing Agency Information

***(5)** Filing Agency: _____

***(6)** Staff filling out Paper Incident Report: _____

(7) Staff Responsible for Incident Follow-up: _____

Initial Report: Incident Classification

***(8A)** Date Incident Discovered: _____ ***(8B)** Approximate Time Incident Discovered: _____
MM/DD/YYYY HH:MM 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: _____ **(9B)** Approximate Time Incident Occurred: _____
MM/DD/YYYY HH:MM 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:

❑ Individual ❑ Other Provider
❑ Family ❑ Other
❑ Reporting Provider ❑ Unknown

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

❑ Yes ❑ No ❑ Unknown

(13) Responsible Site: _____

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

Individual: First Name: Last Name:

***(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 Page #7*)
- ❑ 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

***(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

Individual: First Name: Last Name:

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*

❑ Inflicted by self	❑ Fall	❑ Insect/Animal Bite
❑ Inflicted by staff	❑ Equipment	❑ Motor Vehicle
❑ Inflicted by peer	❑ Restraint-Related	❑ Seizure
❑ Inflicted by other	❑ Transfer/Handling	❑ Other
❑ Environmental	❑ PICA/Eating Non-food items	❑ Unknown

(20A) If Other, Specify: _____

(21) Briefly Describe the Injury Including Cause and Factors: _____

_____

_____

_____

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

❑ Abrasion/Cut	❑ Burn	❑ Head Injury	❑ Poison
❑ Bite	❑ Choking	❑ Internal Injury	❑ Puncture
❑ Bruise	❑ Fracture	❑ Other	❑ Sprain/Strain

(22A) If Other, Specify: _____

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

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

(23A) If Other Specify: _____

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.*

Initial Report: Incident Description II

***(25)** What is the most recent status of the individual? _____

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

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

❑ Individual's Residence	❑ Day Service	❑ Hospital
❑ Family Residence	❑ Work Site	❑ Vehicle
❑ Residential Setting-Other	❑ School	❑ Other
❑ Respite	❑ Community	❑ Unknown

(26B) Location Detail: *CHECK ONE*

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

(26C) Site Location of Incident (address): _____

(26D) *IF NOT AT PROVIDER SITE, INFORMATION ABOUT INCIDENT LOCATION:*
Location Name/Description**:** _____

Location Name and address, if any: _____

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.*

_____

_____

_____

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

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

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

Individual: First Name: Last Name:

Initial Report: Involved Parties

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

	***(29B)** Involvement *SELECT ALL THAT APPLY*	***(29C)** Relationship *SELECT ALL THAT APPLY*
(29A) Involved Party Name: **(29D)** Telephone: ( ) -	❑ Eyewitness to Incident ❑ Person who filled out paper report ❑ Person who reported Incident ❑ Provider/DDS Staff who discovered/first made aware of incident	❑ Reporting Provider Staff ❑ Non-Reporting Provider Staff ❑ Individual/Consumer ❑ Friend ❑Relative ❑Volunteer ❑General Public ❑Other
Involved Party Name: Telephone: ( ) -	❑ Eyewitness to Incident ❑ Person who filled out paper report ❑ Person who reported Incident ❑ Provider/DDS Staff who discovered/first made aware of incident	❑ Reporting Provider Staff ❑ Non-Reporting Provider Staff ❑ Individual/Consumer ❑ Friend ❑Relative ❑Volunteer ❑General Public ❑Other
Involved Party Name: Telephone: ( ) -	❑ Eyewitness to Incident ❑ Person who filled out paper report ❑ Person who reported Incident ❑ Provider/DDS Staff who discovered/first made aware of incident	❑ Reporting Provider Staff ❑ Non-Reporting Provider Staff ❑ Individual/Consumer ❑ Friend ❑Relative ❑Volunteer ❑General Public ❑Other
Involved Party Name: Telephone: ( ) -	❑ Eyewitness to Incident ❑ Person who filled out paper report ❑ Person who reported Incident ❑ Provider/DDS Staff who discovered/first made aware of incident	❑ Reporting Provider Staff ❑ Non-Reporting Provider Staff ❑ Individual/Consumer ❑ Friend ❑Relative ❑Volunteer ❑General Public ❑Other
Involved Party Name: Telephone: ( ) -	❑ Eyewitness to Incident ❑ Person who filled out paper report ❑ Person who reported Incident ❑ Provider/DDS Staff who discovered/first made aware of incident	❑ Reporting Provider Staff ❑ Non-Reporting Provider Staff ❑ Individual/Consumer ❑ Friend ❑Relative ❑Volunteer ❑General Public ❑Other

Initial Report: Notification

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

***(30B)** Name of On-Call person: ______________________________

***(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: ______________________________

***(34C)** Telephone: (_____)_____-_________ ***(34D)** Date/Time of Report: ____________ ____________
MM/DD/YYYY HH:MM AM/PM

***(35A)** Name of Supervisor: _____

***(35B)** Position: _____

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

(35D) Telephone: ( ) - **(35E)** Date/Time of Review: _____ _____
MM/DD/YYYY HH:MM AM/PM

Massachusetts Department of Developmental Services and Massachusetts Rehabilitation Commission
Incident Report - FINAL REPORT

Individual: First Name: Last Name:

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: _____ (MM/DD/YYYY) **(37B)** Hospital Name: _____

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

❑ Near Drowning Inappropriate Sexual Behavior ❑ Aggressive Sexual Behavior Alleged Victim** ❑ Aggressive Sexual Behavior Alleged Perpetrator** ❑ Sexual Misbehavior Alleged Victim ❑ Sexual Misbehavior Alleged Perpetrator ❑ Victim of Physical Altercation ** Significant Behavioral Incident ❑ Involving a Physical Altercation ** ❑ Not Involving a Physical Altercation ** Missing Person ❑ Law Enforcement Contacted** ❑ Law Enforcement Not Contacted Fire ❑ Known Origin – Allegedly Started by Individual** ❑ Known Origin – Not Started by Individual** ❑ Source Unknown** 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**	**Property Damage** ❑ Alleged Victim ❑ Alleged Perpetrator Theft ❑ Alleged Victim ❑ Alleged Perpetrator Other Criminal Activity ❑ Alleged Victim** ❑ Alleged Perpetrator** Transportation Accident ❑ Pedestrian ❑ Motor Vehicle ❑ Other ❑ Emergency Relocation ❑ Unplanned Transportation Restraint ❑ Illness ❑ Injury ❑ Other ❑ Unknown

(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: _____

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

(41A) Actual Date of Discharge: _____
MM/DD/YYYY

(41B) ER/Urgent Care/Crisis Unit/hospital discharge diagnosis:
SEE APPENDIX in INCIDENT REPORT INSTRUCTIONS

Discharge Diagnosis 1: _____

Discharge Diagnosis 2: _____

Discharge Diagnosis 3: _____

(41C) If Other was chosen as a discharge diagnosis, please specify:

_____

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

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

- ❑ Increase in medication(s) (compared to medications before admission)
- ❑ Decrease in medication(s)/Discontinuation of medication(s) (compared to medications before admission)
- ❑ New medication
- ❑ New treatment
- ❑ New instructions received for signs and symptoms
- ❑ Instructions on when to contact the health care practitioner
- ❑ Wound care
- ❑ New equipment
- ❑ Newly diagnosed condition
- ❑ New living situation (specify in additional information below)
- ❑ Transferred to rehabilitation or nursing facility
- ❑ 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*

- ❑ Primary Care Physician (PCP)
- ❑ Admitting Physician
- ❑ Surgeon
- ❑ Specialist
- ❑ Outpatient Psychiatrist
- ❑ Admitting Psychiatrist
- ❑ Other *(specify in additional information below)*
- ❑ None

d

(44) Any Additional/Clarifying Information: _____

_____

_____

_____

Commonwealth of Massachusetts - Department of Developmental Services
Incident Report - FINAL REPORT (continued)

Individual: First Name: Last Name:

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.*

_____

_____

_____

_____

_____

_____

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)

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 *SELECT ALL THAT APPLY*	***(47C)** Relationship *SELECT ALL THAT APPLY*
(47A) Involved Party Name: **(47D)** Telephone: ( ) -	❑ Eyewitness to Incident ❑ Person who filled out paper report ❑ Person who reported Incident ❑ Provider/DDS Staff who discovered/first made aware of incident	❑ Reporting Provider Staff ❑ Non-Reporting Provider Staff ❑ Individual/Consumer ❑ Friend ❑Relative ❑Volunteer ❑General Public ❑Other
Involved Party Name: Telephone: ( ) -	❑ Eyewitness to Incident ❑ Person who filled out paper report ❑ Person who reported Incident ❑ Provider/DDS Staff who discovered/first made aware of incident	❑ Reporting Provider Staff ❑ Non-Reporting Provider Staff ❑ Individual/Consumer ❑ Friend ❑Relative ❑Volunteer ❑General Public ❑Other
Involved Party Name: Telephone: ( ) -	❑ Eyewitness to Incident ❑ Person who filled out paper report ❑ Person who reported Incident ❑ Provider/DDS Staff who discovered/first made aware of incident	❑ Reporting Provider Staff ❑ Non-Reporting Provider Staff ❑ Individual/Consumer ❑ Friend ❑Relative ❑Volunteer ❑General Public ❑Other

Commonwealth of Massachusetts - Department of Developmental Services
Incident Report - FINAL REPORT (continued)

Individual: First Name: Last Name:

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: _____ (MM/DD/YYYY) ***(49B)** Approximate Time Incident Discovered: _____ (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: _____ (MM/DD/YYYY) **(50B)** Approximate Time Incident Occurred: _____ (HH:MM AM/PM)

***(51)** 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 Page #6*)
- ❑ 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 or Psychiatric 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

***(52)** Staff filling out Paper Final Report: _____

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

Commonwealth of Massachusetts - Department of Developmental Services
Incident Report - FINAL REPORT (continued)

Individual: First Name: Last Name:

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

Choose one from the following:

- ❑ Individual
- ❑ Family
- ❑ Reporting Provider
- ❑ Other Provider
- ❑ Other
- ❑ 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 _____

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

❑ 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

Commonwealth of Massachusetts - Department of Developmental Services
Incident Report - FINAL REPORT (continued)

Individual: First Name: Last Name:

Description of Any Injury Associated with the Incident:

***(64)** Is there an Injury? ❑ Yes ❑ No
IF YES, COMPLETE QUESTIONS #65-#68. IF NO, SKIP TO #69A.

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

❑ Inflicted by self	❑ Fall	❑ Insect/Animal Bite
❑ Inflicted by staff	❑ Equipment	❑ Motor Vehicle
❑ Inflicted by peer	❑ Restraint-Related	❑ Seizure
❑ Inflicted by other	❑ Transfer/Handling	❑ Other
❑ Environmental	❑ PICA/Eating Non-food items	❑ Unknown

(65A) If Other, Specify: _____

(66) Briefly Describe the Injury Including Cause and Factors: _____

_____

_____

_____

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

❑ Abrasion/Cut	❑ Burn	❑ Head Injury	❑ Poison
❑ Bite	❑ Choking	❑ Internal Injury	❑ Puncture
❑ Bruise	❑ Fracture	❑ Other	❑ Sprain/Strain

(67A) If Other, Specify: _____

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

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

(68A) If Other Specify: _____

Final Report - Finalization

***(69A)** Name of Person Finalizing Report: _____

***(69B)** Position: _____

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

(69D) Telephone: (_____) _____ - _____ **(69E)** Date/Time of Review: _____ _____
MM/DD/YYYY HH:MM AM/PM