

**Vendor and Long-Term Care Facility
Special Incident Report**
Submitted to
Alta California Regional Center SIR Desk

Section I.

ACRC Special Incident Reporting Requirements: Vendors or Long-Term Health Care Facilities are required to contact Service Coordinators verbally within 24 hours and submit written reports to the SIR Desk within 48 hours of learning of the incident. It is ACRC's preference that all SIRS are typed and submitted to the SIR Desk by e-mail at: sdesk@alta regional.org. If you do not have access to e-mail you may fax it to 916 978-6619.

Consumer's Name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	UCI Number
Diagnosis:			
Date of Birth:	Date of Incident:	Time of Incident:	SIR Tracking Number: (ACRC Use Only)
Consumer Residence: <input type="checkbox"/> Self/Spouse <input type="checkbox"/> Parent/Family <input type="checkbox"/> Residential (CCF/ICF/SNF) SLS: <input type="checkbox"/> Other: <input type="checkbox"/>			
Facility/Provider Responsible:			
Name:			
Address:			
City/ZIP:			
Phone Number:			

Section II.

Type of Incident: Check only the boxes that apply.		
<input type="checkbox"/> Suspected Abuse/Exploitation <input type="checkbox"/> Suspected Neglect <input type="checkbox"/> Sexual Incidents <input type="checkbox"/> Victim of a Crime <input type="checkbox"/> Law Enforcement Involvement <input type="checkbox"/> AWOL <input type="checkbox"/> Emergency Evacuation	<input type="checkbox"/> Injuries/Accidents <input type="checkbox"/> Disease Outbreak <input type="checkbox"/> Choking <input type="checkbox"/> Medication Errors <input type="checkbox"/> Emergency Room Visit (only) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Death	<input type="checkbox"/> Aggressive Acts by Consumer <input type="checkbox"/> Fire Setting <input type="checkbox"/> Suicide Attempts/Threats <input type="checkbox"/> Media Attention <input type="checkbox"/> Transportation Incidents <input type="checkbox"/> Other:
Description of Incident (Please describe the incident, including specific information leading up to the event, location, harm to consumer/ others, persons involved in incident, who was notified when and by whom, etc. Attach additional pages as necessary):		
Alleged Perpetrator (if applicable):		
Location of Incident:		
<input type="checkbox"/> Community Care Facility <input type="checkbox"/> Long-Term Health Care Facility (ICF/SNF) <input type="checkbox"/> Day Program <input type="checkbox"/> Job Site <input type="checkbox"/> Community Setting <input type="checkbox"/> Consumer's Own Residence <input type="checkbox"/> School <input type="checkbox"/> Other:		
Address:		

Agencies/Individuals Notified:	Name of Person Contacted:	Telephone Number:	Date of Contact:
<input type="checkbox"/> Service Coordinator			
<input type="checkbox"/> Community Care Licensing			
<input type="checkbox"/> Department of Public Health Service			
<input type="checkbox"/> Parent/Guardian/Conservator			
<input type="checkbox"/> Physician/ Hospital			
<input type="checkbox"/> Adult Protective Services			
<input type="checkbox"/> Child Protective Services			
<input type="checkbox"/> Long-Term Care Ombudsman			
<input type="checkbox"/> Law Enforcement			
<input type="checkbox"/> Other:			

Section III.

Medical Treatment Necessary: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, give nature of treatment:	
Administered by:	Location Administered:
Follow-up Treatment, if any:	

Law Enforcement <input type="checkbox"/> Not Applicable	
Agency:	Officer:
Report Number:	Telephone Number:
Comments:	

Action Taken/Planned (include person responsible, and how incident was resolved):

What steps will be taken to prevent this incident from occurring again?

Vendor Reporting Incident:	Staff Person Reporting Incident:	Phone Number:
Vendor At time of Incident (If different):	Staff Person in Charge at Time of Incident (If different):	Vendor Number (Reporting Vendor):
Date Report Completed:	Date Report Submitted:	