



Our Mission To provide quality services which enhance the lives of people with disabilities.

## Incident Report

AWOL       General       Medical       Medication/PRN       Substance Abuse

Individual Involved: \_\_\_\_\_ Date of Incident: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day/ Month/ Year

Location of Incident: \_\_\_\_\_ Time of Incident (24hr): \_\_\_\_\_

Staff Reporting: \_\_\_\_\_ Staff Involved: \_\_\_\_\_

### Medication:

PRN       Omitted Dose       Incorrect Dose       Incorrect Med       Incorrect Time  
 Refused       Incorrect Method       Other (specify): \_\_\_\_\_

### ***Section 1 – Description of Incident*** (describe incident using antecedent, behavior and consequence)

**Antecedent** (Brief description of the events leading up to the behavior, eg: triggers, setting events, etc):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Behavior** (Description of what happened):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Consequence** (Describe the outcome of the behavior, including natural and logical outcomes):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Our Mission To provide quality services which enhance the lives of people with disabilities.

### **Section 2 – Restrictive Procedure**

Restrictive Procedure Used (as per behavior support plan):  Yes  No (If Yes, please describe)

---

How long was the procedure utilized: \_\_\_\_\_

Authorization for Procedure use from: \_\_\_\_\_

Effectiveness of Actions Taken (please describe the outcome as well as recommendations for future use):  
\_\_\_\_\_  
\_\_\_\_\_

### **Section 3 – Persons Notified**

(please record the name of the person beside each checked box)

Immediately

Within 24 Hours

Supervisor

---

---

Guardian

---

---

Pharmacist

---

---

Doctor

---

---

Staff Responsible

---

---

Other: \_\_\_\_\_

---

---

### **Section 4 – Instructions Given**

(please describe below instructions given and by whom)

---

---

Staff: \_\_\_\_\_

Print Name

Signature

Date

Administration: \_\_\_\_\_

Print Name

Signature

Date

### **Section 5 – Comments and Follow Up**

(this section for Office Use)

---

---

#### **Office Use Only**

Home

Guardian

Med Record

Record

File

Revised November 2013