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| --- |
| 1. **GENERAL INFORMATION**
 |
| **Child’s Name (Last name, First name):**   | **Date of Birth:**  | **Age:**  | **RIN:**   |
| **Provider Name:**   | **Provider Phone #:**   | **Provider Address:**   |
| **Provider City:**  | **Provider State:**   | **Provider Zip Code:**  | **Is the child his/her own guardian?** [ ]  Yes [ ]  No*(If yes, skip the parent/guardian/caregiver section)* |
| **Name of Child’s Parent/Guardian/Caregiver:**   | **Parent/Guardian/Caregiver Phone #:**  | **Parent/Guardian/Caregiver Email:** [ ]  N/A  |
| **Parent/Guardian/Caregiver Address:**   | **City:**   | **State:**   | **Zip Code:**  |
| 1. **DATE AND TIME OF INCIDENT**
 |
| **Date:** **Start Time:** [ ] AM [ ]  PM **End Time:** [ ] AM [ ]  PM |
| 1. **DATE/TIME/AGENCY SUBMISSION**
 |
| **Date:**  **Time:** [ ]  AM [ ]  PM | **Please identify what notifications have been made**. (*Check all that apply*)[ ]  Law Enforcement [ ]  DCFS [ ] HFS [ ]  Equip for Equality [ ] DHHS/CMS *(death only)* [ ]  Other (*describe*)  |
| 1. **TYPE OF INCIDENT**
 |
| **Please identify what type of critical incident is being reported.** *(Check all that apply)*[ ]  Abuse/Neglect [ ]  Death [ ]  Elopement [ ] Interface w/ Law Enforcement [ ]  Restraint [ ]  Seclusion [ ]  Serious Injury [ ]  Serious Medical Condition [ ]  Sexual Aggression [ ]  Suicide Attempt [ ]  Victimization [ ] Other       |
| **4.a. Complete the following section if a restraint or seclusion was used.** [ ]  N/A |
| **Staff authorizing restraint/seclusion:**  | **Time of order:** [ ] AM [ ]  PM   | **Name of staff receiving order:**  | **Time received:** [ ] AM [ ]  PM   |
| **Were there any injuries to the child as a result of the use of restraint/seclusion?** [ ]  Yes [ ]  No If yes, describe:  | **Was the physical/psychological health of the child reviewed post-restraint/seclusion?**  [ ]  Yes [ ]  No |
| **Time of physical/psychological review completion:** Time: [ ] AM [ ]  PM  | **Name of staff completing physical/psychological health review:**  |
| **Number of Restraints**  | **Restraint Type** | **Length of Restraint(s)** |
| **1.** **2.** **3.**  | **1.** **2.** **3.**  | **1.** **2.** **3.**  |
| **Place of Seclusion** | **Seclusion Length** | **Staff Monitoring Seclusion** |
| **1.** **2.** **3.**  | **1.** **2.** **3.**  | **1.** **2.** **3.**  |
| **Did a debriefing session occur between staff and the child?** [ ]  Yes [ ]  NoDate: Time: [ ] AM [ ]  PM  | **Did a debriefing session occur between all staff involved in the incident?** [ ]  Yes [ ]  NoDate: Time: [ ] AM [ ]  PM  |
| 1. **LOCATION OF THE INCIDENT**
 |
| [ ]  Residential Facility [ ]  Home of Parent/Guardian/Caregiver [ ]  Home of Relative [ ]  Psychiatric Hospital-Inpatient Setting [ ]  Community [ ]  Other (*describe*)  |
| 1. **STAFF INVOLVED IN INCIDENT**
 |
| **First and Last Name:** | **Role in the Incident:**  |
| 1.  | 1.  |
| 2.  | 2.  |
| 3.  | 3.  |
| **Were other children harmed in this incident?** [ ]  Yes [ ]  No | **Were any staff members harmed in this incident?** [ ]  Yes [ ]  No |
| **Was the Parent/Guardian/Caregiver notified of the incident?** [ ]  Yes [ ]  No[ ] N/A |
| 1. **ACTIONS TAKEN (Check all that apply)**
 |
| [ ]  Emergency Department [ ]  First Aid[ ] Hospitalization [ ]  Outpatient Medical Treatment (e.g. prompt care) [ ]  CARES [ ]  Increased Supervision [ ]  Other (*Describe*)  |
| 1. **PERSON COMPLETING REPORT**
 |
| **Name:**   | **Title:**  | **Phone #:**   | **Email:**   |
| 1. **INCIDENT NARRATIVE**
 |
| **Please provide a typed narrative of the incident. Use additional pages as needed and attach to this report.**   |
| 1. **CURRENT STATUS OF CHILD**
 |
| **Please describe the child's current status at the time of this report.**  |
| **HFS OFFICE USE ONLY** Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reviewer Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred to Department of Public Health? [ ]  Yes [ ]  No Date Referred:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |