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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  No  Date: Time: AM  PM | | | | | | | | | | **Did a debriefing session occur between all staff involved in the incident?**  Yes  No  Date: 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  NoN/A | | | | | | | | | | | | | | | | | | |
| 1. **ACTIONS TAKEN (Check all that apply)** | | | | | | | | | | | | | | | | | | |
| Emergency Department  First AidHospitalization  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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |