UNUSUAL INCIDENT/INJURY REPORT

INSTRUCTIONS: NOTIFY LICENSING AGENCY, PLACEMENT AGENCY, AND RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY. SUBMIST WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE. RETAIN COPY OF REPORT IN CLIENT'S FILE.

NAME OF FACILITY	FACILITY NUMBER	TELEPHONE NUMBER
A Coming of Age FFA Foster Home:	**336424303**	**(951) 776-9223**

ADDRESS	CITY/STATE/ZIP
7891 Mission Grove Parkway #B	**Riverside, CA 92508**

CLIENT'S/RESIDENTS INVOLVED	DATE OCCURED	AGE	SEX	DATE OF ADMISSION
1.				
2.				
3.				
4.				

TYPE OF INCIDENT

☐ Unauthorized Absence	☐ Alleged Client Abuse	☐ Rape	☐ Injury-Accident	☐ Medical Emergency
☐ Aggressive Act/Self	☐ Sexual	☐ Pregnancy	☐ Injury-Unknown Origin	☐ Other Sexual Incident
☐ Aggressive Act/Another Client	☐ Physical		☐ Injury-From another Client	☐ Theft
☐ Aggressive Act/Staff	☐ Psychological		☐Injury-From behavior episode	☐ Fire
☐ Aggressive Act/Family, Visitors	☐ Financial	☐ Suicide Attempt	☐ Epidemic Outbreak	☐ Property Damage
☐ Alleged Violation of Rights	☐ Neglect	☐ Other	☐ Hospitalization	☐ Other (explain)

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTECEDNETS LEADING UP TO INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY INJURIES.

PERSON(S) WHO OBSERVED THE INCIDENT/INJURY

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CONTACTED)

MEDICAL TREATMENT NECESSARY ☐ YES ☐ NO IF YES, GIVE NATURE OF TREATMENT:

WHERE ADMINISTERED: ADMINISTERED BY:

FOLLOW-UP TREATMENT, IF ANY: N/A

ACTION TAKEN OR PLANNED (BY WHOM) AND ANTICIPATED RESULTS:

LICENSEE/SUPERVISOR COMMENTS:

NAME OF ATTENDING PHYSICIAN

REPORT SUBMITTED BY:			REPORT REVIEWED/APPROVED BY:		
NAME	TITLE	DATE	NAME	TITLE	DATE

AGENCIES/INDIVIDUALS NOTIFIED (SPECIFY NAME AND TELEPHONE NUMBER)

☐ COMMUNITY CARE LICENSING
Attn: Lisa Enea

☐ LONG TERM CARE OMBUDSMAN

☐ LAW ENFORCEMENT

☐ DCS/CPS SOCIAL WORKER
Attn: _____

☐ PARENT/GUARDIAN/CONSERVATOR

☐ FOSTER FAMILY AGENCY LIAISON
Attn: Afiori Mafi-San Bernardino County