SAN FRANCISCO
HUMAN SERVICES AGENCY

Department of Benefits and Family Support
Family and Children's Services

UNUSUAL INCIDENT/INJURY REPORT

INSTRUCTIONS: Report immediately and no later than 24 hours of incident. Submit written report within 7 days of occurrence.

RETAIN COPY OF REPORT IN CLIENT FILE

NAME OF FACILITY	FACILITY FILE NUMBER	TELEPHONE NUMBER

ADDRESS	CITY, STATE, ZIP

CLIENTS/RESIDENTS INVOLVED	DATE OCCURRED	AGE	GENDER	DATE OF ADMISSION

TYPE OF INCIDENT

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

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTECEDENTS 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:

ACTION TAKEN OR PLANNED (BY WHOM AND ANTICIPATED RESULTS:

LICENSEE/SUPERVISOR COMMENTS:

NAME OF ATTENDING PHYSICIAN

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

AGENCIES/INDIVIDUALS NOTIFIED *(SPECIFY NAME AND TELEPHONE NUMBER)*

☐ RFA UNIT _____ ☐ CHILD PROTECTIVE SERVICES _____
☐ LONG TERM CARE OMBUDSMAN _____ ☐ PARENT/GUARDIAN/CONSERVATOR _____
☐ LAW ENFORCEMENT _____ ☐ PLACEMENT AGENCY _____