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

	NAME AND TITLE	DATE
REPORT SUBMITTED BY:		
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 _____