Health Services for Children with Special Needs, Inc.
1101 Vermont Ave., NW, Suite 1200
Washington, DC 20005
(202) 466-8483

UNUSUAL INCIDENT (UI) REPORT

Patients Initials: ____

Patient Medicaid #: ____

Part I - Reported By:

Person first reporting incident: ____________________________________

Title/Position: ______________________________ Phone #: ____________________

Date/Time Reported: Month __________ Day _________ Yr. _________ Time ______________

Person Reporting Incident to HSCSN: ______________________________

Title/Position: ______________________________ Phone #: ____________________

Date/Time Reported: Month __________ Day _________ Yr. _________ Time ______________

Administration or Office: ____

____

Part II - Type of Incident:

Type of Incident: ____

Date/Time of Incident: Month ______________ Day __________ Yr. _________ Time _______

Location/Place of Incident: ____

Person (s) Involved: ____

Part III - Details of Incident:

(What, How, Why): ____

____

____

Part IV - Action (s) Taken & By Whom

____

____

Part V - (for HSCSN Quality/Accreditation Department Use)

Care Manager Receiving Report: ____

Reviewed By: ____

Date/Time Reported: Month ______________ Day _________ Yr. _________ Time ___________

Reported to: (Check or Specify Name): Med. Director _____ Director _____ Team Leader ____________

Date/Time Reported: Month ______________ Day _________ Yr. _________ Time ___________

*** If necessary, attach separate sheet for additional pertinent documentation. - HSCSN - 01/29/07**