FOSTER CARE

INCIDENT REPORT

Confidential
Restricted Access

Program: _____ **Date of Incident:** _____ **Time of Incident:** **AM/PM**

Client Name: <CFULLNFML> **Gender:** <CG> **Age:** <CAGE> **Admit Date:** <CID>

Witnesses/Persons Involved & Roles: _____

Place Where Incident Occurred: _____

Caregiver Responsible at Time of Incident: _____

Home Name: _____ **Phone Number:** _____

Physical Address: _____

TYPE OF INCIDENT:

☐ Verbal Aggression	☐ Significant Behavior Disruption	☐ Death
☐ Physical Aggression	☐ Injury to Client	☐ Hospitalization medical
☐ Destruction of Property	☐ Injury to Staff	☐ Hospitalization psychiatric
☐ Containment	☐ Self injury non-suicidal	☐ Medical problem
☐ School related problem	☐ Suicidal ideation	☐ Medication error
☐ Sexual behavior	☐ Suicidal gesture	☐ Medication refused
☐ Substance abuse	☐ Suicide attempt	☐ Allegations: abuse/neglect
☐ Criminal behavior	☐ Short personal restraint	☐ Incarceration
☐ Other *(please specify)*:		
☐ Runaway	Time left: AM / PM	Time/Date returned: AM / PM

PREPARED BY *(signature)*	**TITLE**	**DATE COMPLETED**

SUMMARY OF INCIDENT *(For containments, skip this section and complete the containment report)***:**

Detailed description of precipitating events or circumstances and specific behaviors that led to the emergency situation and if applicable, the specific behavior which continued to constitute an emergency situation:

Summary of Incident *(please be specific and state the facts of the incident)*:
** Summary continued on additional page? ☐yes ☐ no*

How was incident resolved?

Client Name: _____ **Date of Incident:** _____ **Time of Incident:** _____ **AM/PM**

SUMMARY OF PRECAUTIONS:

☐ Suicide: Date: _____ Time: _____ AM/PM
☐ Runaway: Date: _____ Time: _____ AM/PM
☐ Aggression: Date: _____ Time: _____ AM/PM
☐ Sexual Acting Out: Date: _____ Time: _____ AM/PM
☐ Other: Date: _____ Time: _____ AM/PM

DATE/TIME OF ACTIONS TAKEN:

☐ Medical Treatment Date: _____ Time: _____ AM/PM
Name of Treating Physician:
Doctor's Instructions for Follow Up:
☐ First Aid Administered Date: _____ Time: _____ AM/PM
☐ Short Personal Restraint Date: Duration: AM/PM
(must last less than 60 seconds)

☐ **Protection from external danger** *(i.e. entering street, hot stove, separating children from physical altercations)*
☐ **Child <5 y/o Disruptive Behavior** *(other efforts have failed)*
☐ **Child >5 y/o Safety Risk** *(i.e. disrobing, provoking, fighting)*

NOTIFICATIONS:	**DATE**	**TIME** *(select AM or PM)*	**NAME OF PERSON CONTACTED**
☐ On Call Staff	_____	_____ ☐AM ☐PM	_____
☐ Supervisor & Case Manager	_____	_____ ☐AM ☐PM	_____
☐ Police **/ Rpt #**	_____	_____ ☐AM ☐PM	_____
☐ JPD/TYC	_____	_____ ☐AM ☐PM	_____
☐ DFPS Caseworker & Supervisor	_____	_____ ☐AM ☐PM	_____
☐ TDFPS Hotline **/ Rpt #**	_____	_____ ☐AM ☐PM	_____
☐ Residential Contract Manager (only reportable incidents)	_____	_____	_____
☐ Other	_____	_____ ☐AM ☐PM	_____

ADMINISTRATIVE USE ONLY:

Reportable: ☐ Non-Reportable: ☐

Operation ID: ☐ CPA

Level of Care: ☐ Basic ☐ Moderate ☐ Specialized

Service Level: ☐ Child Care Services ☐ Treatment Services

REVIEW, RECOMMENDATIONS, AND COMMENTS
ON "CRITICAL" INCIDENTS *(if indicated)*

Title of Staff Person: Case Manager/Caseworker:

Signature: _____ Date: _____

Title of Staff Person: Unit/Foster Care Supervisor:

Signature: _____ Date: _____

Title of Staff Person: Program Director

Signature: _____ Date: _____

Title of Staff Person: Executive Director:

Signature: _____ Date: _____

Title of Staff Person:

Signature: _____ Date: _____