

**VALLEY MOUNTAIN REGIONAL CENTER
SPECIAL INCIDENT REPORT**

Amended

Consumer's Name	Date of Birth	M	F	UCI Number	Date of Report
Consumer's Address	Service Coordinator			Regional Center	

TYPE OF INCIDENT (Reportable Incidents in Bold)

<p><u>Suspected Abuse/Exploitation</u> <i>(Limited to that which has occurred while under care/supervision of a vendor.)</i> Check type:</p> <p><input type="checkbox"/> Physical</p> <p><input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> Financial</p> <p><input type="checkbox"/> Emotional/Mental</p> <p><input type="checkbox"/> Physical and/or chemical Restraint</p> <p><input type="checkbox"/> APS/CPS/LTC Ombudsman/LE Report of suspected Abuse or Neglect made</p> <p><input type="checkbox"/> Exploitation</p> <p><input type="checkbox"/> Verbal</p> <p><input type="checkbox"/> Isolation</p> <p><input type="checkbox"/> Any incident of alleged abuse reported pursuant to Elder Abuse and Dependent Adult Civil Protections Act</p> <p><u>Serious Injury/Accident Which Occurs While the Consumer is Under the Care and Supervision of Any Vendor and Results in One or More of the Following</u> (Check type):</p> <p><input type="checkbox"/> Lacerations requiring sutures, staples, wound adhesive or any wound closure beyond first aid</p> <p><input type="checkbox"/> Puncture wounds requiring medical treatment beyond first aid</p> <p><input type="checkbox"/> Fractures</p> <p><input type="checkbox"/> Dislocations</p> <p><input type="checkbox"/> Bites that break the skin and require medical treatment beyond first aid</p> <p><input type="checkbox"/> Internal bleeding requiring medical Treatment beyond first aid</p> <p><input type="checkbox"/> Any medication errors</p> <p><input type="checkbox"/> Medication reactions that require medical treatment beyond first aid.</p> <p><input type="checkbox"/> Burns that require medical treatment beyond first aid</p> <p><input type="checkbox"/> Injury from seizure requiring medical treatment beyond first aid</p> <p><input type="checkbox"/> Bruising, contusions, or hematomas to Head, eyes, neck, breasts, genitals, rectal or anal regardless of size</p> <p><input type="checkbox"/> Bruising, contusions or hematomas beyond 2 inches or greater</p>	<p><u>Suspected Neglect</u> <i>(Limited to that which has occurred while under care/supervision of a vendor.)</i> Check type:</p> <p><input type="checkbox"/> Failure to Assist in Personal Hygiene, Provision of Food, Clothing, Shelter</p> <p><input type="checkbox"/> Failure to Prevent Malnutrition or Dehydration</p> <p><input type="checkbox"/> Failure to Provide Medical Care</p> <p><input type="checkbox"/> Failure to Protect from Health & Safety Hazards</p> <p><input type="checkbox"/> Failure to prevent two or more falls Within a 30 day period</p> <p><input type="checkbox"/> Exercise a degree of care that a reasonable person would exercise in a position of having the care and custody of an elder or a dependent adult</p> <p><input type="checkbox"/> Abandonment</p> <p><input type="checkbox"/> Any incident of alleged neglect reported pursuant to the Elder and Dependent Adult Abuse Reporting Act</p> <p><u>Emergency Room Visits</u></p> <p><u>Any Unplanned or Unscheduled Hospitalization Due to the Following Conditions.</u> Check type:</p> <p><input type="checkbox"/> Respiratory illness</p> <p><input type="checkbox"/> Seizure-related</p> <p><input type="checkbox"/> Cardiac related</p> <p><input type="checkbox"/> Internal infections</p> <p><input type="checkbox"/> Diabetes/Diabetes related complications</p> <p><input type="checkbox"/> Wound/skin care</p> <p><input type="checkbox"/> Nutritional deficiencies</p> <p><input type="checkbox"/> Bowel obstruction</p> <p><input type="checkbox"/> Involuntary psychiatric admission</p> <p><input type="checkbox"/> ER hospital stay lasting five days or more</p> <p><u>Missing Person</u> <i>(Complete only when reported to law enforcement and if consumer was under care/supervision of a vendor.)</i></p> <p><u>Death</u> <i>(Always Reportable)</i></p>
--	--

Consumer's Name:

UCI#:

Date of Report:

Pressure injuries stage 2 or greater or Unstageable

Any head injury, including concussion, Requiring medical attention

Victim of Crime (Always Reportable) Check type:

- Personal Robbery
- Aggravated assault
- Rape including attempts to commit rape
- Burglary
- Larceny
- Simple assault
- Battery
- Fraud
- Identity or credit theft

- Attempted or actual homicide or manslaughter
- Human Trafficking
- Stalking
- Hate Crime
- Other (Any crime, please specify type)

Supplemental/Optional Reporting

Serious Injury/Accident Which Occurs While the Consumer is Under the Care and Supervision of Any Vendor and Results in One or More of the Following: Check type:

- Injury-Accident
- Injury-Unknown origin
- Injury from seizure
- Injury from another consumer
- Injury from behavior episode

Aggression Displayed by Consumer. Check type:

- Aggressive act to self
- Aggressive act to another consumer
- Aggressive act to staff
- Aggressive act to family/visitor

Other Check type:

- Violation of Rights
- Pregnancy
- Disease outbreak
- Fire
- Suicide attempt
- Threatened suicide
- Medical emergency
- Property damage
- Other sexual incident—Not rape
- Unauthorized absence—law enforcement not notified
- Other: _____

Incident date Definitive Approximate

Time of incident Definitive Approximate

Date incident reported to Regional Center and to whom

Medical Care/Treatment Required? Yes

Consumer's Name:

UCI#:

Date of Report:

No

Relationship of alleged perpetrator to consumer

<input type="checkbox"/> Unknown	<input type="checkbox"/> Another Consumer
<input type="checkbox"/> Self	<input type="checkbox"/> Relative/Family Member
<input type="checkbox"/> Vendor or Employee of Vendor	<input type="checkbox"/> Individual known to consumer (Not a provider or another consumer)
<input type="checkbox"/> Non-Vendor or Employee of Non-Vendor	<input type="checkbox"/> Not applicable

Incident location

<input type="checkbox"/> Acute hospital—not ER	<input type="checkbox"/> Job site	<input type="checkbox"/> Day program
<input type="checkbox"/> Acute hospital—ER	<input type="checkbox"/> Out of home respite	<input type="checkbox"/> Consumer's residence
<input type="checkbox"/> Day care/ Intervention program	<input type="checkbox"/> Community setting	<input type="checkbox"/> Hospice
<input type="checkbox"/> Psychiatric treatment center	<input type="checkbox"/> Home of family	<input type="checkbox"/> Jail or related setting
<input type="checkbox"/> SNF	<input type="checkbox"/> In transit	<input type="checkbox"/> Public school
<input type="checkbox"/> Other _____	<input type="checkbox"/> Subacute or pediatric subacute	<input type="checkbox"/> Rehabilitation facility

Party/Entity reporting incident

Vendor Name: _____	Name: _____
Vendor Type: _____	Address: _____
Vendor Number: _____	City/Zip: _____
<input type="checkbox"/> Self/Spouse <input type="checkbox"/> Residential	Telephone: _____
<input type="checkbox"/> Parent/Family <input type="checkbox"/> Day Program	
<input type="checkbox"/> Other: _____	

Other agencies notified

<input type="checkbox"/> Community Care Licensing	<input type="checkbox"/> DHS Licensing & Certification
<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Adult Protective Services
<input type="checkbox"/> Parent/Guardian/Conservator	<input type="checkbox"/> Long-Term Care Ombudsman
<input type="checkbox"/> Police/Law Enforcement	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Coroner	<input type="checkbox"/> Other: _____

Description of incident

Specific preventative action taken or planned by the vendor:

Consumer's Name:

UCI#:

Date of Report:

--

Reporting Person's Name: _____

Signature: _____ **Date:** _____

(SIR template – revised 03/15/2026) kr