HARBOR REGIONAL CENTER
Service Provider Special Incident Report
Send to: SIRS@harborrc.org
Reports must be submitted within 48 hours
Revised 2/23

Individual's Name:_____	**DOB:**_____	**UCI#:**_____
HRC Service Coordinator:_____		
Service Provider Name:_____	**Vendor #:**_____	
Service Provider Address:_____		
Date Incident Occurred:_____	**Time of Incident:**_____	
Date Vendor Learned of Incident:_____		

Location of Incident:

Hospital ☐	Client's Residence ☐	Client's Day Program ☐	Family Home ☐
In Transit ☐	Emergency Room ☐	Other (specify) ☐ _____	

INCIDENT TYPE (check all that apply):

☐ **Death:**

Official Cause of Death:_____

☐ **Victim of a crime:**

Was the crime reported to the police? Yes ☐ No ☐

Police Department: Report Number:

☐ **Admitted to the Hospital for more than 24 hours:**

Admitting Diagnosis:_____

☐ **Individual has a serious injury or accident requiring treatment beyond first aid.**

☐ **Missing Individual:**

Police Department: Report Number:

☐ **Abuse of the Individual:**

Physical ☐ Sexual ☐ Financial ☐ Chemical Restraint ☐ Emotional ☐

☐ **Neglect of Individual**

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☐ **Medication Error**

Missed dose ☐ Wrong dose ☐ Wrong Medication ☐ Administered to Wrong Person ☐ Wrong time administered ☐

Wrong method of administration ☐ Documentation error ☐ Other ☐

Name of Medication(s) involved in the error:_____

_____

_____

_____

_____

☐ **Medical Attention Required**

Consulted RN, RPH, MD ☐ Consulted poison control ☐ ER visit ☐ Observed Individual ☐

Describe in detail what happened and actions taken

F00009

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Did anyone else witness the incident? Yes ☐ No ☐

Name and contact information (phone & email) of the witness, if available:

_____

Other agencies notified:

CCL/DSS ☐ DHS ☐ Parent/Guardian/Conservator ☐ Physician/Hospital ☐

Police/Sheriff ☐ County Coroner ☐ Other (specify) ☐ _____

Date reported to CCL/DHS: _____

Submitted by:

Name: Title:

Telephone #: Email:

Please use this space below to add any other information you think is important about the special incident:

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