Amended

VALLEY MOUNTAIN REGIONAL CENTER
SPECIAL INCIDENT REPORT

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)

___ **Suspected Abuse/Exploitation** ***(Limited to that which has occurred while under care/supervision of a vendor.)*** **Check type:**
- ___ **Physical**
- ___ **Sexual**
- ___ **Financial**
- ___ **Emotional/Mental**
- ___ **Physical and/or chemical Restraint**
- ___ **APS/CPS/LTC Ombudsman/LE Report of suspected Abuse or Neglect made**
- ___ **Exploitation**
- ___ **Verbal**
- ___ **Isolation**
- ___ **Any incident of alleged abuse reported pursuant to Elder Abuse and Dependent Dependent Adult Civil Protections Act**

___ **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):**
- ___ **Lacerations requiring sutures, staples, wound adhesive or any wound closure beyond first aid**
- ___ **Puncture wounds requiring medical treatment beyond first aid**
- ___ **Fractures**
- ___ **Dislocations**
- ___ **Bites that break the skin and require medical treatment beyond first aid**
- ___ **Internal bleeding requiring medical Treatment beyond first aid**
- ___ **Any medication errors**
- ___ **Medication reactions that require medical treatment beyond first aid.**
- ___ **Burns that require medical treatment beyond first aid**
- ___ **Injury from seizure requiring medical treatment beyond first aid**
- ___ **Bruising, contusions, or hematomas to Head, eyes, neck, breasts, genitals, rectal or anal regardless of size**
- ___ **Bruising, contusions or hematomas beyond 2 inches or greater**

___ **Suspected Neglect** ***(Limited to that which has occurred while under care/supervision of a vendor.)*** **Check type:**
- ___ **Failure to Assist in Personal Hygiene, Provision of Food, Clothing, Shelter**
- ___ **Failure to Prevent Malnutrition or Dehydration**
- ___ **Failure to Provide Medical Care**
- ___ **Failure to Protect from Health & Safety Hazards**
- ___ **Failure to prevent two or more falls Within a 30 day period**
- ___ **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**
- ___ **Abandonment**
- ___ **Any incident of alleged neglect reported pursuant to the Elder and Dependent Adult Abuse Reporting Act**

___ **Emergency Room Visits**

___ **Any Unplanned or Unscheduled Hospitalization Due to the Following Conditions. Check type:**
- ___ **Respiratory illness**
- ___ **Seizure-related**
- ___ **Cardiac related**
- ___ **Internal infections**
- ___ **Diabetes/Diabetes related complications**
- ___ **Wound/skin care**
- ___ **Nutritional deficiencies**
- ___ **Bowel obstruction**
- ___ **Involuntary psychiatric admission**

___ **ER hospital stay lasting five days or more**

___ **Missing Person** ***(Complete only when reported to law enforcement and if consumer was under care/supervision of a vendor.)***

___ **Death** ***(Always Reportable)***

___ **Pressure injuries stage 2 or greater or Unstageable**

___ **Any head injury, including concussion, Requiring medical attention**

___ **<u>Victim of Crime</u> *(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

___ **<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:**
- ___ **Injury-Accident**
- ___ **Injury-Unknown origin**
- ___ **Injury from seizure**
- ___ **Injury from another consumer**
- ___ **Injury from behavior episode**

___ **<u>Aggression Displayed by Consumer.</u> Check type:**
- ___ **Aggressive act to self**
- ___ **Aggressive act to another consumer**
- ___ **Aggressive act to staff**
- ___ **Aggressive act to family/visitor**

___ **<u>Other</u> 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

- ___ Unknown
- ___ Self
- ___ Vendor or Employee of Vendor
- ___ Non-Vendor or Employee of Non-Vendor
- ___ Another Consumer
- ___ Relative/Family Member
- ___ Individual known to consumer (Not a provider or another consumer)
- ___ Not applicable

Incident location

- ___ Acute hospital–not ER
- ___ Acute hospital–ER
- ___ Day care/ Intervention program
- ___ Psychiatric treatment center
- ___ SNF
- ___ Other ___
- ___ Job site
- ___ Out of home respite
- ___ Community setting
- ___ Home of family
- ___ In transit
- ___ Subacute or pediatric subacute
- ___ Day program
- ___ Consumer's residence
- ___ Hospice
- ___ Jail or related setting
- ___ Public school
- ___ Rehabilitation facility

Party/Entity reporting incident

Vendor Name: ___ **Vendor Type:** ___ **Vendor Number:** ___	**Name:** ___ **Address:** ___
___ Self/Spouse ___ Residential	**City/Zip:** ___
___ Parent/Family ___ Day Program	**Telephone:** ___
___ Other: ___	

Other agencies notified

- ___ Community Care Licensing
- ___ Child Protective Services
- ___ Parent/Guardian/Conservator
- ___ Police/Law Enforcement
- ___ Coroner
- ___ DHS Licensing & Certification
- ___ Adult Protective Services
- ___ Long-Term Care Ombudsman
- ___ Other: ___
- ___ Other: ___

Description of incident

Specific preventative action taken or planned by the vendor:

Reporting Person’s Name: ___________________________________

Signature: ____ **Date:** _____________________

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