INCIDENT MANAGEMENT CONTINGENCY FORM

Complete and send to the IM Point Person who must file a report within 24 hours

****Medication Error: Please Also Complete Page #2 ****

Date of Report:______________________

SS#: XXX-XX-______________________
(Last four digits only)

Date Incident Occurred:________________
Time Incident Occurred:________________
Date Incident Recognized:______________
Time Incident Recognized______________

Name:_________________________________
(Individual / Victim)

Address:_______________________________

____

Phone:________________________________

Provider: Human Resources Center, Inc.
294 Bethel School Road
Honesdale, PA 19431

Phone: 570-253-3782

County of Registration:__________________

Reporters Name:_________________________

Date of Birth:_________________**Sex:**________

Relationship:___________________________

Description of Incident (Antecedent if applicable):

____
____
____
____
____

Witness(s):

____
____

Hospital (As applicable):____

Services Received at Hospital/ER/Urgent (Tests, etc.) **Forward a copy of discharge paperwork to the point person.**

____
____
____

Diagnosis:

____
____

Discharge Instructions:

____
____
____

Follow-up: **Include date of follow up appointment/s, if available at the time of report.**

____
____

Services and Supports offered to the individual (victim): (i.e. professional counseling, victims assistance)

____
____

INCIDENT MANAGEMENT CONTINGENCY FORM
To be completed for Medication Errors
Page #2

Name of Medication: ____

Controlled Substance: Yes____ No____

1) **Name of staff making error:**______________________________________

2) **Was staff working longer than their regular work hours at time of error? Yes _______ No _________**

3) **Length of time staff who made error has been giving medications.** ____________________

4) **Number of medications to be given to this consumer/resident at the same time the error was made.** ____________________

5) **Number of medications this consumer/resident receives on a daily basis?** ____________________

6) **Number of consumers/residents that the staff who made the error has to give medications to around the same time as the error occurred.** ____________________

7) **Reason for error**____
____
____

Notification: (Made for ALL incidents)

Relative/Legal Guardian:______________________________ **Notified By:**____________________________
Date:____________________________

Supports Coordinator:__________________________ **Notified By:**____________________________
Date:____________________________

Other Notifications:____________________________ **Notified By:**____________________________
(i.e.) Adult Protective Services
Date:____________________________

____ ________________________________
Signature of Individual Completing this Report **Date**

______________________________________ ________________________________
Signature - HCSIS Admin. **Date Received by HCSIS Admin.**

____

(Point Person use only)
EIM#:___________________
I to I Optima Assessment Received: _________________ Optima Assessment forwarded to AE: ________________
(Date/Time) (Date/Time)
Primary Category: ____________________________
Secondary Category: __________________________
Certified Investigator: _________________________

JT 11.28.22