Revised 06/01/2012

DOH/DHI Use Only
Case #:

New Mexico Department of Health
Community Based
INCIDENT REPORT (SFY 2013)

SECTION 1 - CONSUMER INFORMATION

Name of Consumer	*First:	Middle:	*Last:
Social Security #		*Gender: ☐Male ☐Female	*DOB: - -
Residence Address	*Street Address:	*City:	*Zip: *Phone:

*Consumer Competency Level: ☐High ☐Moderate ☐Low

*ADLs (Consumer Needs Assistance With) Check All That Apply: ☐Walking ☐Wheelchair ☐Bathing ☐Eating ☐Transfer ☐Total Care ☐None
Verbal: ☐Yes ☐No

Diagnosis(es):
Name of Doctor & Phone #:
List Consumer's Current Medications or Attach Medication Administration Record (MAR):

SECTION 2 - DESCRIPTION OF INCIDENT
(Staff person with the most direct knowledge of incident fills out this section.)

***TYPE OF ALLEGED INCIDENT**

Reminder: Abuse, Neglect and Exploitation must be reported to APS via Fax (505) 476-4913 or Phone (866) 654-3219

☐**ABUSE** ☐**NEGLECT** ☐**EXPLOITATION**

☐Natural/Expected Death ☐Unexpected Death
☐Emergency Services ☐Law Enforcement Involvement ☐Environmental Hazard

Person responsible for individual's care at time of incident:
Name: Title: Phone:

If this person is employed by a provider agency, which agency:

Has this happened before? ☐Yes ☐No | Was provider notified of incident? ☐Yes ☐No
Were other consumers/individuals present? ☐Yes ☐No | If Yes, Other Consumer's initials:
Was anyone else present at the time of the incident: ☐Yes ☐No | If Yes, Identify below:

Name:	Title or Relationship:	Phone:
Name:	Title or Relationship:	Phone:

*Date of Incident: | *Time of Incident: ☐AM ☐PM ☐Unknown
*Location of Incident:

Describe what you saw and/or what you heard in order of occurrence:

***Before the Incident:**

***During the Incident:**

***After the Incident:**

Person Completing Sections 1 and 2

*Confidentiality Desired ☐Yes ☐No	*Name:	*Agency:	*Title/Relationship:	*Phone:	*Date Completed:	*Time Completed:

DOH Fax (800) 584-6057
When faxing information that is not on this form, please label it with consumer's name and incident date.

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Consumer Information	First Name:	Middle:	Last Name:	SSN:	Date of Incident:

SECTION 3 - AGENCY INFORMATION

Reporting Agency:		Incident Coordinator:		
Address:	City:	Zip:	County:	Phone:

SECTION 4 - ADMINISTRATIVE INFORMATION *Check the applicable box(es) below:

☐DD Waiver [If DD, check Jackson ☐Yes ☐No] ☐Medically Fragile Waiver
☐ICF-MR (Jackson) ☐DD/State General Fund ☐Family/Infant/Toddler ☐Other

DD Programs ONLY - Type of residential services received by the consumer:
☐Supported Living ☐Family Living ☐Independent Living ☐None

Initial actions taken by the agency to assure health and safety:

Was law enforcement contacted? ☐Yes ☐No | Is the consumer still with the agency? ☐Yes ☐No

Plans for further actions in response to the incident:

SECTION 5 - NOTIFICATIONS TO AGENCIES REQUIRED

Always notify DOH/DHI within 24 hours of the incident via FAX: (800) 584-6057
Notify Adult Protective Services(APS)/Child Protective Services (CPS) to report Abuse, Neglect or Exploitation ONLY

CPS Fax: (505) 841-6691 APS Fax: (505) 476-4913 or Phone APS: (866) 654-3219
Name of Person Phoned:

Legal Guardian ☐None ☐Notified	Guardian Name and Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:	State:	Zip:	
Independent Case Manager ☐None ☐Notified	Case Management Agency Name:		Person Making Contact:		
	Case Manager Name and Phone #:		Date:	Time:	
	Street Address:	City:	State:	Zip:	
Other ☐None ☐Notified	Name and Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:	State:	Zip:	

Person Completing Sections 3, 4 and 5

*Name:	*Title/Relationship:	*Phone:	*Date Completed:	*Time Completed:

By typing your name below, you are effectively signing this document. Your typed name is acceptable as a replacement for your written signature.

*Name:	*Date

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SECTION 6 - OPTIONAL INFORMATION
(If choosing to file this page, it is due within 72 hours of initial report. This page is NOT required.)

Consumer Information	First Name:	Middle:	Last Name:	SSN:	Date of Incident:

Hospital admission required: ☐Yes ☐No	If yes, discharge date:
Medical Records FAXED to DHI: ☐Yes ☐No	Date faxed:
Diagnosis(es) given at emergency intervention: ☐Yes ☐No	List Diagnosis(es)

Comments:

Does this consumer have an existing medical diagnosis (es) that may impact the reported incident? ☐Yes ☐No
If yes, provide diagnosis(es):

If this report involves abuse, neglect or exploitation and the responsible provider wants to confirm that a person in your employ has committed the alleged event, check the appropriate box, then sign and date at the bottom of this page:

☐ABUSE ☐NEGLECT ☐EXPLOITATION

The following measures have been put in place to remedy the situation and to ensure the health and safety of the consumer:

Additional information that may be pertinent to this incident:

Authorized by:	Last Name:	First Name:	Title:	Agency:

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