SAN DIEGO REGIONAL CENTER

Special Incident Report and Shared Information for SDRC Vendors and Long-Term Care Facilities

Instructions for provider Special Incident Reporting (Cal. Code Regs. Tit. 17, § 54327)

1. Verbally notify SDRC within 24 hours of incident by calling the assigned Service Coordinator or On Call worker
2. Submit written SIR within 48 hours by fax, email: vendorsirs@sdrc.org OR enter via SIR Service Provider Portal
3. Notify the appropriate licensing agency according to Title 22 regulations, if applicable
4. Notify authorities (APS, CPS/CFWB, LTC Ombudsman, Law Enforcement) per mandated reporting requirements for SIRs involving a victim of crime and/or an allegation of abuse or neglect
5. Keep a copy of the completed SIR for the individual's file

Client Name: _____ UCI #: _____ DOB: _____ Age: _____

Service Coordinator: _____ Vendor #: _____

Incident Date: _____ Incident Time: _____ AM ☐ PM ☐ UNKNOWN ☐

Date Vendor LEARNED of Incident: _____ Date Vendor CALLED SDRC: _____

Date Vendor Submitted WRITTEN Report: _____

Incident Location: _____ Was Medical Care/Treatment Required? Y ☐ N ☐

1. INCIDENT TYPES(S) - CHECK ALL THAT APPLY

☐ **Death**

☐ **Medication Error**
(please fill out Section 7)

Victim of Crime
- ☐ Aggravated Assault
- ☐ Burglary
- ☐ Larceny
- ☐ Personal Robbery
- ☐ Rape Or Attempted Rape

Suspected Abuse/Exploitation
(please fill out Section 8)
- ☐ Alleged Violation of Rights
- ☐ Emotional/Mental Abuse
- ☐ Financial Abuse
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Physical/Chemical Restraint

Suspected Neglect Including Failure To:
(please fill out Section 8)
- ☐ Assist w/ Personal Hygiene
- ☐ Prevent Malnutrition/Dehydration
- ☐ Protect From Health/Safety Hazard
- ☐ Provide Care - Elder/Adult
- ☐ Provide Food/Clothing/Shelter
- ☐ Provide Medical Care

Missing Person
- ☐ Missing Person - Law Notified
- ☐ Unauthorized Absence - Law Not Notified

Medical Treatment - Beyond First Aid
(please fill out Section 6)
- ☐ Bites That Break The Skin
- ☐ Burns
- ☐ Choking
- ☐ Condition requiring Medical Intervention
- ☐ Emergency Room
- ☐ Dislocation
- ☐ Fracture
- ☐ Internal Bleeding
- ☐ Laceration Requiring Sutures/Staples/Dermabond
- ☐ Puncture Wounds Requiring Treatment

Unplanned/Unscheduled Hospitalization Due To :
(please fill out Section 6)
- ☐ Cardiac-related
- ☐ Diabetes-related
- ☐ Seizure-related
- ☐ Internal Infection
- ☐ Nutrition Deficiency
- ☐ Respiratory Illness
- ☐ Wound/Skin Care
- ☐ Involuntary Psychiatric Hospitalzation
- ☐ Voluntary Psychiatric Hospitalization

Behavior
- ☐ Aggressive Act Involving A Weapon
- ☐ Aggressive Act To Another Client
- ☐ Aggressive Act To Family/Visitors
- ☐ Aggressive Act To Self
- ☐ Aggressive Act To Staff
- ☐ Arrests
- ☐ Drug/Alcohol Abuse
- ☐ Community Safety
- ☐ Fire Setting
- ☐ Psych Emergency Team/No Hospitalization
- ☐ Property Damage
- ☐ Severe Verbal Threats
- ☐ Suicide Threat
- ☐ Suicide Attempt
- ☐ Theft By A Consumer

Injury From:
- ☐ Accident
- ☐ Another Consumer
- ☐ Behavior Episode
- ☐ Seizure
- ☐ Unknown Origin

Other
- ☐ COVID-19
- ☐ Disease Outbreak
- ☐ Other Sexual Incident
- ☐ Pregnancy
- ☐ Other: _____

2. AGENCIES NOTIFIED AND/OR INVOLVED

	Contact Name	Date Notified	Phone #	Report #
☐ Community Care Licensing (DSS)				
☐ Health Care Licensing (DHS)				
☐ Parent/Guardian/Conservator				
☐ Law Enforcement				
☐ Adult Protective Services				
☐ Child Protective Services / CFWB				
☐ Long-Term Care Ombudsman				
☐ Other				

3. DESCRIPTION OF INCIDENT

(who/what/where/when/why, description of perpetrator, treatment administered, transported to hospital etc)

4. SPECIFIC PREVENTATIVE ACTION TAKEN/PLAN TO PREVENT REOCCURRENCE

(new or modified services/supports/equipment, followup care, next planning team meeting etc.)

5. ACTION(S) TAKEN BY VENDOR IN RESPONSE TO SPECIAL INCIDENT

☐ Staff Training ☐ Staff Terminated ☐ Planning Team Meeting ☐ Referral to Clinical Services

☐ Staff Suspended ☐ Policies Revised ☐ Review/Revise Behavioral Plan ☐ Other: _____

6. FOR HOSPITALIZATIONS & ER VISITS ☐ Not Applicable

Hospital Name: _____ Admission Date: _____

Diagnosis (if available): _____

Discharge Date (if available): _____ Discharged To (if available): _____

Followup needed after discharge (i.e. PT, specialist appointment) (if available): _____

Does client require any support/equipment daily? _____

Medication Changes (if applicable): _____

7. FOR MEDICATION ERRORS ☐ Not Applicable

Type of Medication Error (check all that apply)

☐ Missed Dose ☐ Wrong Medication ☐ Wrong Time ☐ Documentation Error: _____

☐ Wrong Dose ☐ Wrong Person ☐ Wrong Route _____

Name and dosage of medication: _____

_____

_____ Any adverse reactions? _____

Day(s) medication was to be given: _____ Time medication was to be given: _____ AM ☐ PM ☐

Primary Care Physician (MD,NP,PA, or Pychiatrist) notification (name&date): _____

8. FOR ALLEGED PERPETRATOR ☐ Not Applicable

Name of Alleged Perpetrator: _____ Age: _____

Has this person previously abused the client? Y/N : ___ If yes, when was last incident? _____

Relationship to consumer: ☐ Self ☐ Another Consumer ☐ Relative/family member ☐ Vendor/employee of vendor

☐ Other individual known to consumer ☐ Unknown ☐ Other: _____

If client required medical attention due to abuse, please fill out Section 6 "Hospitalization & ER visit" above

9. WITNESS ☐ Not Applicable

Witness Name: _____ Address: _____ Phone # _____

10. REPORT SUBMITTED BY

Name: _____ Title: _____

Vendor Name: _____ Vendor Email: _____

Date Completed: _____ Telephone #: _____

DDS Followup Questions Per Incident Type, Portal Website, SIR Form Examples, and SIR Tutorials can be found at:
https://www.sdrc.org/special-incident-reporting