Reset Form

REPORT OF INCIDENT / INJURY

State Form 46009 (R5 / 5-23)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

The information in this document is confidential according to 45 CFR 160 and 164, IC 16-39, and 42 CFR Part 2.

ADDRESSOGRAPH OR LABEL

INCIDENT INFORMATION

Date of incident *(month, day, year)*	Time *(24 hour)*	Unit/Department/Location	Date of report *(month, day, year)*	Time *(24 hour)*

DETAILED INCIDENT LOCATION *(where incident happened)*

☐ ON on grounds ☐ OF off grounds ☐ IN indoors ☐ OD outdoors

Select one below

☐ AP Appointment ☐ AR Activity Rec. ☐ BA Bathroom ☐ BE Bedroom ☐ BK Breakroom ☐ CA Clinic Area	☐ CL Classroom ☐ CO Community ☐ CY Courtyard ☐ DR Dining Room ☐ GY Gymnasium ☐ HA Hallway	☐ HM Home ☐ KI Kitchen ☐ LO Lobby-Reception ☐ LR Dayroom/Living Rm. ☐ NS Nurses Station ☐ OA Office/ADM.	☐ PL Parking Lot ☐ PY Playground/yard ☐ RA Ramp ☐ RO Roadway ☐ SE Seclusion/ Restraint ☐ ST Stairs	☐ SW Sidewalk ☐ QR Quiet Room/ Chill Out Room. ☐ VE Vehicle ☐ WV work/vocational ☐ UN Unknown	☐ OR Other _____ _____

INCIDENT TYPE *(**alleged) - Select one below*

☐ AL Allergy/Allergic Reaction ☐ AP Alcohol /Drug Poss. ☐ AW AWOL/Elopement ☐ BM Behavioral Mgmt. ☐ Restraint Manual ☐ Restraint Mechanical ☐ Seclusion ☐ CH Choking	☐ CI Contact/Intentional ** ☐ CO Contraband ☐ CS Contact/Sexual** ☐ CU Contact/Unintentional** ☐ EB Exposure/Blood/Body Fluids ☐ EC Expos/Dangerous Chemical ☐ ER Equipment Related ☐ FA Fall	☐ FI Fire ☐ IG Ingestion/Foreign Object ☐ IN Injury Unknown Origin ☐ LI Lifting ☐ ME Medication Error ☐ OH Overheating/Heat ☐ PD Property Destruction	☐ SA Suicide Attempt ☐ SE Seizure ☐ SI Self-Injurious Behavior ☐ TH Theft ** ☐ UI Unauthorized Items ☐ VA Vehicle Accident ☐ OR Other: _____

INFORMATION REGARDING INDIVIDUALS INVOLVED IN INCIDENT *(use letters from categories below)*

Person's Category	Person's Role	Unit	MRN	Name	Age

Person Category	Person's Role
CE Contract Employee	PP Perpetrator
EE Employee	VI Victim
PA Patient/Client	WI Witness
VI Visitor	
VO Volunteer	

INJURY *(check applicable categories)*

Type of Injury

☐ NO No Injury
☐ AB Abrasion
☐ BI Bite
☐ BU Burn
☐ CO Contusion/ Bruise
☐ EP Bloody Nose
☐ LA Laceration/Cut
☐ MI Muscle Injury
☐ NS Needle Stick
☐ PA Pain
☐ PS Poss. Break/Fracture
☐ PU Puncture
☐ RE Redness
☐ SC Scratch
☐ ST Sting
☐ SB Sunburn
☐ SW Swelling
☐ OR Other: _____

Body Part Affected

☐ AD Abdomen
☐ LA Arm, Left/Hand/Wrist
☐ RA Arm, Right/Hand/Wrist
☐ BK Back
☐ BU Buttocks
☐ CH Chest
☐ LR Ear, Left
☐ RR Ear, Right
☐ LE Eye, Left
☐ RE Eye, Right
☐ FI Fingers
☐ GE Genitalia
☐ HF Head/Face
☐ LL Leg/Knee/Foot, Left
☐ RL Leg/Knee/Foot, Right
☐ MT Mouth/Teeth
☐ NE Neck
☐ NO Nose
☐ LS Side, Left
☐ RS Side, Right
☐ TO Toes
☐ OR Other: _____

Apparent Cause

☐ AM Animal
☐ CK Chemical/External
☐ CN Chemical/Internal
☐ EV Environmental Factors
☐ EQ Equipment
☐ FU Furnishings
☐ IN Insect
☐ LI Lifting
☐ MD Medical Devices
☐ NS Non-staff person
☐ OT Other Patient/Client
☐ SE Seizure
☐ SI Self-intentional
☐ SU Self-unintentional
☐ SP Staff Person
☐ WI Water Intoxication
☐ UN Unknown/Unk. Origin
☐ OR Other: _____

Treatment Given

☐ NT No Treatment
☐ FA Minor/First Aid
☐ MI Medical Intervention
☐ HO Hospitalization
☐ DO Death Occurred

Diagnostics/Exams/Test

☐ NC Neurochecks
☐ XR X-Ray
☐ ER Emergency Room
☐ OR Other: _____

Treatment Location

☐ ON On Grounds Med Fac.
☐ OF Off Grounds Med Fac.

Treatment Given By

☐ OR Other Facility Staff
☐ FS Facility Nurse
☐ FP Facility Physician
☐ NF Non-facility Staff

DESCRIPTION OF INCIDENT

Brief, essential information, no opinions/conclusions

Signature/Title	Date Signed *(month/day/year)*	Time *(24 hour)*

NURSING COMMENTS/RN ASSESSMENT

Brief, essential information, no opinions/conclusions

Signature/Title	Date Signed *(month/day/year)*	Time *(24 Hour)*

PROVIDER COMMENTS

Brief, essential information, no opinions/conclusions

Signature/Title	Date Signed *(month/day/year)*	Time *(24 Hour)*

INTERNAL NOTIFICATIONS *(if applicable)*

Supervisor notified/reviewed	Risk Manager notified/reviewed	Provider notified ☐ Yes ☐ No	Comment Security notified ☐ Yes ☐ No
Date/Time notified *(24 hour)*	Date/Time notified *(24 Hour)*	Date/Time notified *(24 Hour)*	

AGENCIES NOTIFIED OF THE INCIDENT

Name of Agency	Date *(month, day, year)*	Time	Name of Person Notified	Person Completing Notification