REGIONAL CENTER OF ORANGE COUNTY
Special Incident Report, Other Events, and Observations

SUBMIT SIRs TO RCOC VIA DocuSign, E-MAIL: SIRemail@rcocdd.com, OR FAX: (714) 796-5800

REPORT SUBMITTED BY					
Name			Vendor Name		
Title			Vendor #		
Telephone #			DHS-L&C Lic. #		
Signature/Date			DSS-CCL Lic. #		
INDIVIDUAL INVOLVED			Date Became Aware		
Name			Date of Report		
UCI Number			Incident Date/Time		
Date of Birth			Incident Location		

INCIDENT TYPE(S) – CHECK ALL THAT APPLY

REQUIRED BY TITLE 17, §54327

- ❑ Death of an individual (regardless of cause or location)
- ❑ Reasonably suspected neglect:
  - ❑ Failure to provide medical care
  - ❑ Failure to prevent malnutrition/dehydration
  - ❑ Failure to protect from health/safety hazard
  - ❑ Failure to assist with personal hygiene
  - ❑ Failure to provide food/clothing/shelter
  - ❑ Failure to provide care
- ❑ Reasonably suspected abuse/exploitation:
  - ❑ Physical
  - ❑ Psychological
  - ❑ Sexual
  - ❑ Fiduciary
  - ❑ Physical restraint
  - ❑ Chemical restraint
- ❑ Individual is missing and the vendor has filed a Missing Person Report with a law enforcement agency
- ❑ Individual was the victim of a crime (regardless of location)
- ❑ A serious injury/accident, including:
  - ❑ Dislocation
  - ❑ Fracture
  - ❑ Laceration requiring sutures/staples/Dermabond
  - ❑ Burns, bites, puncture wounds or internal bleeding requiring treatment beyond first aid
- ❑ Unplanned or unscheduled hospitalization due to:
  - ❑ Respiratory illness
  - ❑ Cardiac-related activity
  - ❑ Diabetes-related activity
  - ❑ Seizure-related activity
  - ❑ Wound/skincare
  - ❑ Internal infection
  - ❑ Nutritional deficiencies
- ❑ Involuntary psychiatric admission

MEDICATION-RELATED – REPORT ALL ERRORS

- ❑ **ANY MEDICATION ERROR**
- ❑ A serious injury/accident involving a medication reaction requiring treatment beyond first aid

Name of Medication	Dosage Schedule

OTHER EVENTS/OBSERVATIONS

- ❑ Alleged violation of individual's rights
- ❑ Voluntary psychiatric hospitalization
- ❑ Medical emergency
  - ❑ Emergency room visit
- ❑ Unauthorized absence
- ❑ Injury:
  - ❑ From a seizure
  - ❑ From a behavior episode
  - ❑ From a peer
  - ❑ Accident
  - ❑ Unknown origin
- ❑ Suicide episode:
  - ❑ Threat
  - ❑ Attempt
- ❑ Property damage
- ❑ Verbal threats
- ❑ Diagnosis of communicable disease/parasite
- ❑ Event which may result in criminal charges/legal action
- ❑ Law enforcement contact
- ❑ Arrest
- ❑ Health and safety issue
- ❑ Other sexual incident:
  - ❑ Sexual harassment
  - ❑ Inappropriate contact
- ❑ Behavior episode:
  - ❑ Aggressive act to self
  - ❑ Aggressive act to staff
  - ❑ Aggressive act to peer
  - ❑ Aggressive act to family or visitor
  - ❑ Aggressive act to community member
  - ❑ Other
- ❑ Use of restrictive behavior intervention
- ❑ Other

Additional Incident Types Required for FHA per Title 17, §56093

- ❑ Any occurrence/allegation of abuse
- ❑ Event which may result in criminal charges or legal action
- ❑ Event which may result in denial of individual's right(s)
- ❑ Event which appears to have a significant negative effect on individual's health, safety, or well-being
  - ❑ Poisoning
  - ❑ Catastrophe
  - ❑ Emergency treatment
  - ❑ Fire or explosion

OTHER AGENCIES/INDIVIDUALS INVOLVED				
	Contact Name	**Contact Date**	**Telephone**	**Report Number**
❑ Community Care Licensing (DSS)				
❑ Licensing and Certification (DHS)				
❑ Parent/Guardian/Conservator				
❑ Physician/Hospital				
❑ Police/Sheriff				
❑ County Coroner				
❑ Other Family Member/Vendor				

INVESTIGATING AGENCY INVOLVED			
❑ Adult Protective Services	❑ Investigated	❑ Declined	❑ For Information Only
❑ Child Protective Services	❑ Investigated	❑ Declined	❑ For Information Only
❑ Long Term Care Ombudsman	❑ Investigated	❑ Declined	❑ For Information Only

For the following sections, attach separate page(s) for additional information if necessary

DESCRIPTION OF INCIDENT (Title 17 requires a description of the alleged perpetrator, if applicable)

IMMEDIATE ACTION TAKEN BY SERVICE PROVIDER/VENDOR/OTHER

MEDICAL TREATMENT NECESSARY	❑ Yes ❑ No	If yes, describe nature of treatment

Administered At		Administered By	

Follow-Up Treatment, If Any

PLAN TO PREVENT FURTHER OCCURRENCES

ADDITIONAL COMMENTS (Include the name and address of any witness to the incident)

Clear Form