D.6 INCIDENT REPORT FORM

VA New York / New Jersey Health Care Network
HCHV Contract Residential Care Program
Incident Report

(To be completed and faxed to the VA HCHV Contract Residential Care Liaison within 24 hours of an incident occurring.)

Name of Veteran: _____

Social Security No.: _____

Agency / Facility: _____

Contract No.: _____

Description of the Incident

Date of Incident: _____ **Time of Incident:** _____

Location of Incident: _____

Type of Incident:

- ☐ Death (N)
- ☐ Fire (N)
- ☐ Drug / Police Raid (N)
- ☐ Suicide / Suicide Attempt
- ☐ 911 Call (Police / Fire Dept. / Paramedics / Other)
- ☐ Severe Medical Illness / Emergency
- ☐ Severe Psychiatric Illness / Emergency
- ☐ Sexual Assault
- ☐ Act of violence by veteran against other resident(s) or staff
- ☐ Abusive behavior by veteran against staff
- ☐ Act of violence by other resident(s) or staff against veteran
- ☐ Abusive behavior by staff against veteran
- ☐ Accident (Specify: _____)
- ☐ Medication Problem:
  - ◊ Medication not sent
  - ◊ Incorrect medication sent
  - ◊ Missing medications
  - ◊ Adverse drug reaction
- ☐ Other (Specify: _____)

(N) = National report required

Brief Description of the Incident ***(please include circumstances leading up to the incident, names of witnesses, if any, and outcomes; attach additional pages as needed):***

Action(s) taken by Contract Provider:

Name of VA Staff Contacted: _____

Report Completed By: _____

Title: _____ **Date: _____**

Signature: _____

Phone: _____

For VA HCHV Contract Residential Care Liaison

Additional information and actions taken including date(s):

Report filed:

☐ **Nationally** **Sent to: _____**

Date: _____

☐ **Locally** **Sent to: _____**

Date: _____

Follow Up Required (if any):

VA Liaison: _____

Signature: _____ **Date: _____**