GUAM BEHAVIORAL HEALTH & WELLNESS CENTER
790 Gov. Carlos G. Camacho Rd. Tamuning, Guam 96913
TEL: (671) 647-5440 FAX: (671) 649-6948

INCIDENT REPORT FORM

First Responder:	**Incident Date:**	**Incident Time:**

Location:	**Location Details**
☐ GBHWC Main facility	
☐ Residential Facility	
☐ Consumer Residence	
☐ Community/Other	

Person Involved

Name:	**Gender:** ☐ **Female** ☐ **Male**

Person Type:	☐MR#	☐ Visitor	☐ Staff	☐ Student/Intern	☐ Other

Others involved in the incident, and witness to incident: (first list all victims of assault or accidents, then witnesses)

	Name:	**MR#**	**Title**	**Victim**	**Witness**	**Relationship**
1				☐	☐	
2				☐	☐	
3				☐	☐	

Administrative Reportable Incidents		**Consumer Safety Events/Critical Incidents**	
☐ Burglary/Theft/damage to property	☐ Missing medical record	☐ Consumer abduction within GBHWC facility	☐ Incident Involving Injury
☐ Discovery of contraband	☐ Medical emergency	☐ Aggression/Violence	☐ Fall
☐ Search and Seizure *(i.e., court ordered)*		☐ Abuse	☐ Medication Error
☐ Unethical Conduct (specify):		☐ Biohazard Accidents	☐ Neglect
☐ HIPAA Violation/breach of confidentiality		☐ Communicable disease	☐ Wandering
☐ Natural Disaster (substantial threat to facility operations or safety)		☐ Elopement	☐ Suicide/attempted suicide
☐ Physical injury of a visitor requiring first aid		☐ Human rights violation	☐ Unauthorized possession of weapons
☐ Employee Injury		☐ Sexual Assault	☐ Vehicular accidents
☐ Reportable disease requiring notification of public health authorities		☐ Unauthorized possession of legal or illegal substances	☐ Overdose
☐ Other (Specify):		☐ Infection Control	☐ Other (Specify):

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Incident Report: Describe what happened **(who, what, where, when, why, and how)**

Severity Outcome:

- ☐ No harm event: did not threaten the involved person's health, safety, and /or welfare.
- ☐ Adverse event: did threaten the involved person's health, safety, and /or welfare.
- ☐ Close Call: consumer safety event that was prevented and did not reach the consumer.
- ☐ Hazardous or unsafe conditions: a circumstance that increases the probability of an adverse event.
- ☐ Sentinel Event: resulted in the loss of life, loss of function, or permanent harm, severe temporary.

Persons or agency notified:	**Indicate name:**				
☐ **Supervisor**	☐ **Risk Manager**	☐ **CPS**	☐ **APS**	☐ **GPD**	**Other** (specify):

Intervention:			
☐ Use of seclusion	☐ Use of restraint	☐ Other (Specify):	☐ NA
Type of PCM Restraint use:	☐ **Transportation**	☐ **Immobilization**	☐ **Other (specify):**
Duration:	Time Started:	Time Ended:	
Was the PCM Restraint(s) utilized properly ☐ **Yes** ☐ **No**		**Was the PCM Procedures effective** ☐ **Yes** ☐ **No**	

I, the Reporter, certify this report to be accurate and complete: *(complete injury section, if with injuries).*			
Reporter Printed Name	**(Signature)**	**Date**	**Time**

I, the Immediate Supervisor, have reviewed this report and hereby certify that all documentation is complete and correct:			
Immediate Supervisor/Charge Nurse On duty	**(Signature)**	**Date**	**Time**

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IMMEDIATE SUPERVISOR REVIEW			
Debriefing Done: ☐ Yes ☐ No ☐ NA **Date of Debriefing:**			
1. Describe all supervisory actions taken (include any and all supervisor responses taken, alternate staff assignments, etc.)			
2. Could anything have been done to prevent the incident?		☐ Yes	☐ No
If yes, explain:			
3. Are there corrective measures that have been or will be put in place as a result of the incident?		☐ Yes	☐ No
If yes explain corrective measures:			
Immediate Supervisor/Charge Nurse on duty Printed Name	**(Signature)**	**Date**	**Time**
Division Administrator Printed Name	**(signature)**	**Date**	**Time**
Division Administrator's COMMENTS:			

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RISK MANAGER REVIEW			
Print Name-Title	**(Signature)**	**Date**	**Time**

COMMENTS:

DEPUTY DIRECTOR/DIRECTOR REVIEW			
Recommendation: ☐ **internal investigation** ☐ **No internal Investigation** ☐ **other**			
Printed Name-Title	**(Signature)**	**Date**	**Time**

COMMENTS:

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INJURY REPORT

Name of Person with Injury:

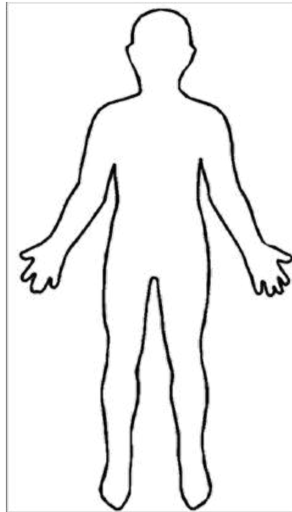
Name of Examiner: **Date Examined:**

Injury incurred:	☐ **Yes** ☐ **No**	**Total # of persons injured:**

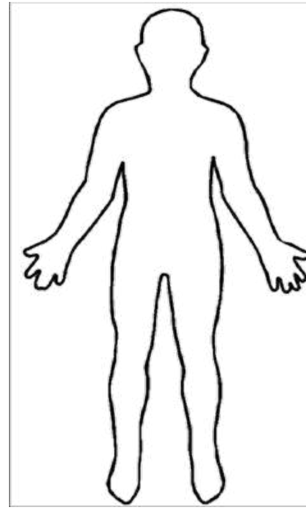
Cause of Injury:

- ☐ Fall
- ☐ Trip
- ☐ As a result of Physical Restraint
- ☐ Physical Assault
- ☐ As a result of seclusion
- ☐ As a result of Self-Harm
- ☐ Accident *(specify):*
- ☐ Other *(specify):*

Description and Severity:



Front



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Recommendation: ☐ No Treatment needed ☐ First Aid ☐ treatment by GBHWC Nurse or MD

☐ Outside medical treatment required ☐ Other *(Specify):*

Outcome of treatment provided if any:

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I certify that this section of this report is complete and accurate

Print Name	**(Signature)**	**Title**	**Date:**