CONFIDENTIAL AND PRIVELEGED INFORMATION

DCFS PRTF Incident Reporting Form v.07.01.2020

Not a part of the Medical Record. Do not distribute externally.

Document relevant and appropriate progress note into the medical record per documentation standards							
Incident #:	Location of incident	t: SITE: PRTF Oasis PRTF North PRTF Enterprise					
Date of Incident:	Youth bedroom	Staff office Quiet Room					
Time of Incident:	Recreation area	Common area/hallway/dayroom School/Class					
Day: 🛛 M 🗍 Tu 🗍 W 🗍 Th 🗍 F 🗍 Sa 🗍 Su	Public area	Outside area or parking lot Dining room/kitchen					
,	 Other:	Treatment area					
Person(s) Affected: Name (Last, First, M):							
Age: Gender: 🗌 M 🗍 F 🗍 O Admit Date: Unit: Ethnicity: Most recent diagnosis:							
Name of attending physician: Notified? Yes No INDIVIDUALS INVOLVED INDIVIDUALS INVOLVED INDIVIDUALS							
Youth Staff Other NAME: Youth Staff Other NAME:							
Youth Staff Other NAME:		Youth Staff Other NAME:					
INCIDENT CLASS (Check all applicable boxes)							
Class I Incident: YOUTH (Notify CPM II) Youth death Youth suicide		Class II Incident: YOUTH (Notify CPM II) Manual guidance of youth Restraint of youth. Type of restraint Length of hold					
Youth suicide attempt		Vouth allergic reaction (to?)					
Youth elopement Length of elopem	ent in hours	Vouth suicide gesture or suicidal ideation					
Youth sexual incident		☐ Youth minor adverse drug reaction ☐ Pharmacy follow-up					
Youth-to-staff aggression resulting in injury		Medication error					
Youth-to-youth aggression resulting in injury		Youth-to-youth physical aggression-no injury					
Youth allegation of abuse		Youth-to-staff aggression no injury					
Major medication error resulting in harm to youth		Deliberate self-inflicted injury					
Significant adverse drug reaction Pharmacy Fo	ollow-up	Fall or other accidental injury Fall without injury					
Youth threat of harm to self or others		Recreational injury					
Youth significant injury (e.g., fracture, major traum	na, etc.)	Contraband					
AMA discharge		Property damage or loss					
Youth medical emergency		Major milieu disruption					
Youth other (Describe)		Other (Describe)					
Class III Incident: Visitor (General Liability: Forward IR to CPM to forward to Sa	afety Committee)	Class IV Incident: Employee (Worker's Comp: Forward to CPM to notify HR)					
Name:		Name:					
Address:		Job Title and ID#:					
		Address:					
Phone:							
Purpose of visit: Youth visit Vendor Provider		Phone:					
Other:		Injury/Damage Sustained:					
Injury/Damage sustained:		Physical injury Property damage (auto) Theft					
Physical injury Property damage (auto) Theft		Other (Describe)					
Other (Describe)		C-1 Form completed Referral for medical treatment					
Police report number (if none taken, write n/a)	_	Police report number (if none taken, write n/a)					
Class V Incident: (Safety: Forward IR to CPM to forward to Safety Committee) Weapon Equipment Malfunction Non-youth threat of harm to self or others State of Nevada property damage Other (describe)							
Was youth placed on 15-minute monitoring? Yes No If "Yes", who approved, and what was the justification for approval (the reason)?							

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DESCRIPTION OF INCIDENT (Facts Only)						
If applicable, how was this incident converted into a teaching opportunity?						
If Restraint, (Report to BMT & SREP, complete forms packet, complete Class IV and V boxes as well)						
If elopement, what was the outcome? (Report filed? JPO Involvement? Return on own? Etc.)						
Was there law enforcement involvement? 🔲 Yes 🗌 No With whom?						
Was there Mobile Crisis Response Team or similar involvement, transport, and/or hospitalization? 🗌 Yes 🗌 No Explain:						
NURSING NOTES						
NOTIFICATION(S)						
Physician notified: 🗌 Yes 🗌 No	Physician's name:					
By Whom:	Comments:					
Date:			Date:	Time:		
Time: Supervisor notified:YesNo	Superviser's name:					
By Whom:	Supervisor's name: Comments:					
Date: Time:	comments.					
LRP notified: Yes No	Legally Responsible Person's name:					
By Whom:	Comments:					
Date: Time:						
Other notified: Yes No Family/Other Person's name and relationship to youth:						
By Whom:						
Date: Time:						
Form completed by:						
Printed Name		Signature and credentials	• -	Date		
Witnessed by:						
Printed Name		Signature and credentials		Date		
Nursing Supervisor Comments and Re	commendations <i>OR</i> 🗌 N/A					
Signature and Title:		Date:				
Medical Director Comments and Recommendations <i>OR</i> N/A:						
Medical Director Comments and Reco						
Signature and Title:		Date:		_		
CPM I or Supervisor Comments and Recommendations:						
Signature and Title:		Date:		_		
CPM II Comments and Recommendations:						
Signature and Title:		Date:				
Signature and Title:		Date:		-		

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