*STATE OF NEVADA*
*DEPARTMENT OF HEALTH AND HUMAN SERVICES*
*DIVISION OF PUBLIC AND BEHAVIORAL HEALTH*

# SELF REPORT FORM

**According to NAC 449.74491 Any allegation of abuse, neglect, misappropriation of property, elopement, fall/injury, must be reported to the Division of Public and Behavioral Health within 24 hours. A final report must be received within 5 working days.**

**PLEASE TYPE IN ALL NECESSARY INFORMATION, THEN FAX TO: 702-486-6520; ATTENTION: SELF REPORT**

**HAND WRITTEN REPORTS ARE NOT RECOMMENDED**

**1. FACILITY NAME AND ADDRESS:**

_______________________________________________________________________________

**2. CONTACT PERSON, PHONE NUMBER AND EMAIL ADDRESS:**

_______________________________________________________________________________

**3. ALLEGED INCIDENT OCCURRED ON:** ___________ **AT:** ____________ ☐ **AM** ☐ **PM**

**A. RESIDENTS INVOLVED: (ATTACH RESIDENT FACE SHEET)**

**RESIDENT NAME:** ___________________ **DATE OF BIRTH:** _________________
**DATE ADMITTED:** ___________________ **ROOM #:** ________________________

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**RESIDENT NAME:** ___________________ **DATE OF BIRTH:** ________________
**DATE ADMITTED:** ___________________ **ROOM #:** _______________________

**B. ALLEGED STAFF INVOLVED: (IF APPLICABLE)**

**ALLEGED STAFF:** ______________________ **LICENSE #:** ______________

**ALLEGED STAFF:** ______________________ **LICENSE #:** ______________

**ALLEGED STAFF:** ______________________ **LICENSE #:** ______________

**4. TYPE OF REPORT:**

☐ **INITIAL** ☐ **FINAL** ☐ **INITIAL & FINAL** ☐ **ADDITIONAL INFO**

**5.TYPE OF ALLEGED INCIDENT:**

☐ **RESIDENT TO RESIDENT ALTERCATION** ☐ **EMPLOYEE TO RESIDENT ALTERCATION**

☐ **ELOPEMENT** ☐ **RESIDENT FALL** ☐ **INJURY OF UNKNOWN ORIGIN**

☐ **MISAPPROPRIATION OF PROPERTY** ☐ **OTHER:** ____________________________

**6. BRIEF DESCRIPTION OF EVENT: (ATTACH MEDICAL RECORD REVIEW, CNA RECORDS, INTERVIEWS, X-RAY RESULTS, ETC.)**

**7. WAS RESIDENT TAKEN TO EMERGENCY ROOM?** ☐ **YES** ☐ **NO**

**IF YES, WHAT HOSPITAL WAS THE RESIDENT TAKEN TO?**

_______________________________________________________________

**8. DATE RESIDENT RETURNED TO THE FACILITY:** _________________________
**(ATTACH HOSPITAL RESULTS IF APPLICABLE)**

**9. (A) IF THE PERPETRATOR WAS A STAFF MEMBER, WAS THE ALLEGATION SUBSTANTIATED?** ☐ **YES** ☐ **NO**

**IF YES, WAS STAFF SUSPENDED?** ☐ **YES** ☐ **NO**

**IF YES, WAS STAFF TERMINATED?** ☐ **YES** ☐ **NO**

**(B) IF ALLEGATION WAS SUBSTANTIATED, PLEASE ATTACH A COPY OF THE LETTER SENT TO THE APPROPRIATE OCCUPATIONAL BOARD. (EX: NURSING, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SOCIAL WORKER, RESPIRATORY THERAPIST, ETC.)**

**(C) IF STAFF WAS REINSTATED, DESCRIBE ACTIONS TAKEN: (IF AN INSERVICE WAS HELD, ATTACH ALL SUPPORTING DOCUMENTATION INCLUDING DATE, ATTENDANCE ROSTER, OBJECTIVES, IF IT WAS MANDATORY, ETC.)**

______________________________________________________________________

**CONCLUSION:**

**10. BRIEF DESCRIPTION OF HOW YOU CAME TO YOUR CONCLUSION: (ATTACH FACILITY POLICIES IF APPLICABLE)**

______________________________________________________________________________

**11. DESCRIBE OR ATTACH A COPY OF RESIDENT CARE PLAN(S) PERTAINING TO THE INCIDENT:**

______________________________________________________________________________

**12. DESCRIBE ACTION STEPS TAKEN TO PREVENT FUTURE OCCURRENCE:**

________________________________________________________________________________

**13. WERE OTHER ENTITIES NOTIFIED, PLEASE MARK BOXES THAT APPLY:**

- ☐ **AGING AND DISABILITY SERVICES**
- ☐ **LAW ENFORCEMENT: INCIDENT/REPORT ID# _________________**
- ☐ **PUBLIC GUARDIAN**
- ☐**FAMILY MEMBER**
- ☐ **PHYSICIAN**
- ☐ **OTHER: ___________________________________________________**

***PRINT AND FAX TO: 702-486-6520; ATTENTION: SELF REPORT***

***MAKE SURE ALL REQUESTED DOCUMENTS ARE ATTACHED.***

***PLEASE RETAIN A COPY FOR YOUR RECORDS***