



EASTERN LOS ANGELES REGIONAL CENTER

1000 S. Fremont Ave. • P.O. Box 7916 • Alhambra, CA 91802-7916 • (626) 299-4700 • FAX (626) 281-1163

VENDOR SPECIAL INCIDENT REPORT

VENDOR NAME: _____ VENDOR NUMBER: _____

VENDORING REGIONAL CENTER: ELARC OTHER: _____

ALL SECTIONS MUST BE COMPLETED. DO NOT LEAVE ANY SECTION BLANK

Consumer's Name	D.O.B.	GENDER	DATE OF REPORT
Address/Telephone Number Living with: Self/Spouse Parent Residential		Female	
		Male	
Check applicable boxes: verbal non-verbal ambulatory non-ambulatory			

Type of Incident: DO NOT use this form to report a Consumer DEATH. Use ELARC - QA #268a FOR Deaths ONLY.

- | | |
|---|---|
| Missing Person-Law Notified | Unplanned Hospitalization |
| Suspected Abuse + Type: _____ | Due to condition below: |
| Suspected Neglect + Type: _____ | Respiratory Seizure Related |
| Serious Injury/Accident (select injury type): | Cardiac Related Internal Infection |
| Laceration Bites breaking skin | Diabetes Related Wound/Skin Care |
| Fracture Internal Bleeding | Nutritional Deficiency Psychiatric Admission |
| Dislocation Medication Error | Other Condition-Specify: _____ |
| Burn Medication Reaction | |
| Puncture Wound Other - _____ | Victim of Crime Type: _____ |
| Suicide Attempt/Threat | Crime by Consumer |
| Aggressive Act | Arrest of Consumer |
| Medical Emergency | Unauthorized Absence |
| Other Sexual Incident | Poisoning |
| Pregnancy | Catastrophe |
| Alleged Violation of Rights | Fire/Explosion |
| Major Property Damage | Communicable Disease |
| Epidemic Outbreak | Health/Safety Threat |
| Minor Injury Requiring Medical Treatment | |
| Other: _____ | |

+ For Suspected Abuse or Neglect, follow Mandated Reporter Requirements by reporting to the appropriate protective services agency. Attach copy of Suspected Abuse Report and complete All Sections of this Form.

Date & Time of Incident	Location of Incident	Date Verbal Report made to ELARC & Name of Person Reported To - Must be reported within 24 hours
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Vendor Special Incident Report (continued)

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Description of Incident: Include Sequence of Events that lead to Incident, Description or Name of Alleged Perpetrator, Names of Witnesses, Names of Persons Present at Time of Incident

<u>INDIVIDUALS/AGENCIES NOTIFIED & DATE OF NOTIFICATION</u>					
Law Enforcement:					
Police	Sheriff				
		(Station Name)	(Officer Name)	(Report Number)	(Telephone/FAX) (Date)
Licensing:					
		(Office Name)	(Licensing Analyst Name)	(Telephone/FAX)	(Date)
DCFS/APS/Ombudsman:					
		(Agency Name)	(Worker Name)	(Report Number)	(Telephone/FAX) (Date)
Regional Center:					
		(Center Name)	(Service Coordinator)	(Telephone/FAX)	(Date)
Parent/Authorized Representative:					
		(Name)	(Relationship)	(Telephone/FAX)	(Date)
Other:					
		(Name)	(Address)	(Relationship)	(Telephone/FAX) (Date)

Vendor Special Incident Report (continued)

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ALL SECTIONS MUST BE COMPLETED. DO NOT LEAVE ANY SECTION BLANK.

Medical Treatment Necessary: Yes No

If yes, describe the nature of treatment administered, who administered, where administered, medications given, etc.

Action Taken by Vendor, Consumer, Authorized Representative and/or other Agencies in response to the incident:

Preventive Action Taken and/or Planned & by Whom:

Report Submitted by:

Name/Title: _____

Address: _____

Vendor Name: _____

Telephone Number: _____

Date/Time: _____

ELARC USE ONLY:

Date E-Mail was sent:

Date Report Printed:

Signature:
