Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D
Commissioner

Maine Department of Health and Human Services
Licensing and Certification
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011

Reportable Incident Form for Certified, Licensed or Registered Providers
Complaint Line: 207-287-9308
Fax Line: 207-287-9307 email: dlrs.complaint@maine.gov

Office Use Only
ACTs Number _____
File Only

Facility Information

Facility Name:	City/Town:	
Facility Licensed as:		
Name of Person Reporting the Incident :	Title:	Phone Number:

Type of Incident:
Abuse ☐ Neglect ☐ Exploitation ☐ Misappropriation of Resident/Patient Property ☐
Injuries of Unknown Origin ☐ Other ☐ _____

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

Residents/Patients Involved

List all residents/patients involved:

Full Names	Unit	Room Number

List all witnesses (Include any staff present at the time of the incident):

Full name	Title/Relationship	Phone Number

List the people alleged to be involved in the incident, if applicable. If staff members are listed, please indicate their status of employment, ex.; suspended/working/leave/etc.

Full Name	Title/Relationship	Phone	Employment Status

Description of Incident: (Please include how & why and if this incident has occurred before).

Assessment of the Resident/Patient

What was the resident/patient's mental and functional status at the time of the event? Check any that apply. ☐ Alert ☐ Oriented ☐ Confused ☐ Combative ☐ Non-ambulatory ☐ Independent ambulatory ☐ Wheel chair dependent ☐ Other (specify)

_____

What interventions were in place at the time of the incident? Please describe in full below:

_____
_____
_____

Extent of injuries and any treatment that was provided (Describe in detail):

_____
_____
_____
_____

Were there any adverse effects to the resident/patient (physical or mental)?
Yes ☐ No ☐

Actions Taken by the Facility

Was the Physician notified? Yes ☐ No ☐ If yes, date and time: _____
Were the Family, Guardian, etc. notified? Yes ☐ No ☐
Was resident transferred to a hospital? Yes ☐ No ☐

Where were they transferred to? _____

When were they transferred? _____

What was the outcome, if known (admitted, fracture, death, etc.)? _____

_____

Have any new interventions or corrective actions been implemented? Describe in detail below:

Check any of the authorities below that have been notified.

☐ Police/Law Enforcement ☐ Adult Protective ☐ Attorney General's Office
☐ Medical Examiner
☐ Other(s): _____

Signature Block

Name (please print): _____ **Title:** _____

Signature: _____ **Date:** _____

Please forward a follow-up report to the department within 5 days