Lawrence County Developmental Disabilities
604 Carlton Davidson Lane, Coal Grove, OH 45638
740-532-7401
www.lawrencedd.org

Incident Report Form

EMAIL COMPLETED REPORT TO:

Tiffany Stephenson
tstephenson@socog.org
Phone: 937-798-9353

Provider Name & Address	
Individual's Name:	DOB:
Address:	City/County:
Date of Incident: Time of Incident: ☐ AM ☐ PM	
Location of Incident (home in bathroom, at the mall, lunchroom at work):	
Description of Incident (Who, What, Where, When):	
Injury – Describe Type & Location:	
Immediate Action to Ensure Health & Welfare of Individuals:	
Name of Primary Person(s) Involved:	Relationship to Individual:
Witnesses to Incident:	Others Involved:

Type of Notification	Name/Title	Date/Time
Guardian / Advocate/Family		
SSA		
Licensed or Certified Provider		
Staff or Family living at the Individual's home		
Law Enforcement (Name, Badge Number, Jurisdiction, Contact Info)		
Children's Services (if applicable)		
County Board		
Administrator (Required for ICF)		
Senior Management		
Other Providers of Service		
Investigative Agent (SOCOG)		

Additional Information/or Administrative Follow-Up:

A. Further Medical Follow-up:

_____
_____
_____

B. Administrative Action:

_____
_____
_____
_____

Printed Name: _____

Signature: _____ Title: _____ Date:_____

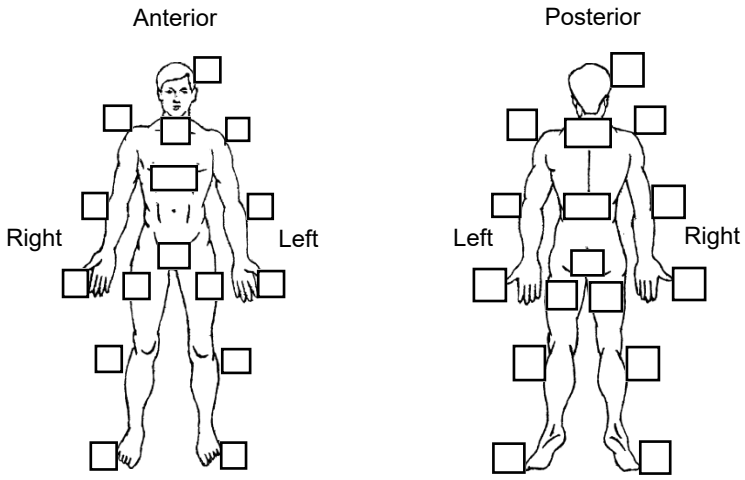
Body Part Injured:

- ☐ Head or Face
- ☐ Mouth / Teeth
- ☐ Hands/Arms
- ☐ Feet/Legs
- ☐ Neck or Chest
- ☐ Abdomen
- ☐ Back/Buttocks
- ☐ Genitals

Detailed description of area(s) injured:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Check All Areas Injured



Causes and Contributing Factors:

_____
_____
_____
_____
_____
_____

Preventive measures: (For Provider's internal use)

_____
_____
_____
_____
_____
_____
_____

Administrator Review: _____ Date: _____