STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES
Incident Report Follow-Up Form for DDS Form 255 and Form 255m
I.D.PR 009 Attachment G

Client Name:_____ DDS # _____ Incident Date: _____/_____/_____
Address: _____
Date Follow-up Initiated: ____/____/____ Date Follow-up Completed: ____/_____/_____

Type of Incident (Check all that apply): Critical Incident? ____Yes ____NO
___ Injury ___ Restraint ___ Unusual Incident ___ Med. Error: Describe:_____
_____

Family/Guardian Notified: Name: _____ Date: _____
Comments: _____
_____

Supervisor Review:	Date:	Corrective Actions: _____
Name: _____	_____	_____
Title: _____		_____
		_____

Referrals as applicable (e.g. PRC, Physician, Nurse, A/N): List all and Comment: _____
_____
_____
_____

Follow-up Actions, Describe: _____
_____
_____
_____

Resolution:
Resolved? _____Yes _____No Resolution/Completion Date: _____/_____/_____
If no, explain, list further actions as necessary:_____
_____
_____
_____

Other Review:

Person Completing Form:
Signature: _____ Title: _____ Date: ____/____/____

Cc: Client file; Client Program file; Case manager; Others, as appropriate (e.g., RN, PRC, etc.)