

Tracking Number:
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## Unusual Incident Reporting (UIR) Form

Please submit the UIR, along with all required documentation, to HFS Children’s Behavioral Health Unit via email  
(HFS.CBH@illinois.gov) or fax  
(217-782-5672), using the subject line “UIR.”

<b>1. GENERAL INFORMATION</b>				
Child’s Name (Last name, First name):		Date of Birth:	Age:	RIN:
Provider Name:		Provider Phone #:	Provider Address:	
Provider City:	Provider State:	Provider Zip Code:	Is the child his/her own guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If yes, skip the parent/guardian/caregiver section)</small>	
Name of Child’s Parent/Guardian/Caregiver:		Parent/Guardian/Caregiver Phone #:	Parent/Guardian/Caregiver Email: <input type="checkbox"/> N/A	
Parent/Guardian/Caregiver Address:		City:	State:	Zip Code:
<b>2. DATE AND TIME OF INCIDENT</b>				
Date: _____		Start Time: _____	<input type="checkbox"/> AM <input type="checkbox"/> PM	End Time: _____
				<input type="checkbox"/> AM <input type="checkbox"/> PM
<b>3. DATE/TIME/AGENCY SUBMISSION</b>				
Date: _____		Please identify what notifications have been made. (Check all that apply)		
Time: <input type="checkbox"/> AM <input type="checkbox"/> PM		<input type="checkbox"/> Law Enforcement <input type="checkbox"/> DCFS <input type="checkbox"/> HFS <input type="checkbox"/> Equip for Equality <input type="checkbox"/> DHHS/CMS (death only) <input type="checkbox"/> Other (describe) _____		
<b>4. TYPE OF INCIDENT</b>				
Please identify what type of critical incident is being reported. (Check all that apply)				
<input type="checkbox"/> Abuse/Neglect <input type="checkbox"/> Death <input type="checkbox"/> Elopement <input type="checkbox"/> Interface w/ Law Enforcement <input type="checkbox"/> Restraint <input type="checkbox"/> Seclusion <input type="checkbox"/> Serious Injury <input type="checkbox"/> Serious Medical Condition <input type="checkbox"/> Sexual Aggression <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Victimization <input type="checkbox"/> Other: _____				
<b>4.a. Complete the following section if a restraint or seclusion was used. <input type="checkbox"/> N/A</b>				
Staff authorizing restraint/seclusion:	Time of order: <input type="checkbox"/> AM <input type="checkbox"/> PM	Name of staff receiving order:	Time received: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Were there any injuries to the child as a result of the use of restraint/seclusion? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, describe: _____			Was the physical/psychological health of the child reviewed post-restraint/seclusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Time of physical/psychological review completion: Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		Name of staff completing physical/psychological health review:		
<b>Number of Restraints</b>		<b>Restraint Type</b>		<b>Length of Restraint(s)</b>
1.	1.	1.		
2.	2.	2.		
3.	3.	3.		
<b>Place of Seclusion</b>		<b>Seclusion Length</b>		<b>Staff Monitoring Seclusion</b>
1.	1.	1.		
2.	2.	2.		
3.	3.	3.		
Did a debriefing session occur between staff and the child? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did a debriefing session occur between all staff involved in the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		

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### 5. LOCATION OF THE INCIDENT

- Residential Facility  
  Home of Parent/Guardian/Caregiver  
  Home of Relative  
  Psychiatric Hospital-Inpatient Setting  
  Community  
 Other (*describe*) \_\_\_\_\_

### 6. STAFF INVOLVED IN INCIDENT

<b>First and Last Name:</b>	<b>Role in the Incident:</b>
1.	1.
2.	2.
3.	3.

**Were other children harmed in this incident?**  Yes  No     
 **Were any staff members harmed in this incident?**  Yes  No  
**Was the Parent/Guardian/Caregiver notified of the incident?**  Yes  No  N/A

### 7. ACTIONS TAKEN (Check all that apply)

- Emergency Department  
  First Aid  
  Hospitalization  
  Outpatient Medical Treatment (e.g. prompt care)  
  CARES  
 Increased Supervision  
 Other (*Describe*) \_\_\_\_\_

### 8. PERSON COMPLETING REPORT

<b>Name:</b>	<b>Title:</b>	<b>Phone #:</b>	<b>Email:</b>
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### 9. INCIDENT NARRATIVE

Please provide a typed narrative of the incident. Use additional pages as needed and attach to this report.

### 10. CURRENT STATUS OF CHILD

Please describe the child's current status at the time of this report.

#### HFS OFFICE USE ONLY

Date Received: \_\_\_\_\_     
 Reviewer Name: \_\_\_\_\_     
 Date Reviewed: \_\_\_\_\_  
 Referred to Department of Public Health?  Yes  No     
 Date Referred: \_\_\_\_\_