EASTERN LOS ANGELES REGIONAL CENTER

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

RESET

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
- Suspected Abuse + Type:
- Suspected Neglect + Type:
- Serious Injury/Accident (select injury type):
  - Laceration
  - Fracture
  - Dislocation
  - Burn
  - Puncture Wound
  - Bites breaking skin
  - Internal Bleeding
  - Medication Error
  - Medication Reaction
  - Other -
- Unplanned Hospitalization

Due to condition below:

- Respiratory
- Cardiac Related
- Diabetes Related
- Nutritional Deficiency
- Other Condition-Specify:
- Seizure Related
- Internal Infection
- Wound/Skin Care
- Psychiatric Admission

- Victim of Crime Type:
- Suicide Attempt/Threat
- Aggressive Act
- Medical Emergency
- Other Sexual Incident
- Pregnancy
- Alleged Violation of Rights
- Major Property Damage
- Epidemic Outbreak
- Crime by Consumer
- Arrest of Consumer
- Unauthorized Absence
- Poisoning
- Catastrophe
- Fire/Explosion
- Communicable Disease
- 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**

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

INDIVIDUALS/AGENCIES NOTIFIED & DATE OF NOTIFICATION

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)

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: _____

SUBMIT SIR

(The submit button works on Adobe Only. Not on a web browser)

PRINT