ILLINOIS DEPARTMENT OF Healthcare and Family Services

Tracking Number:

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."

1. GENERAL INFORMATION

Child's Name (Last name, First name):	Date of Birth:	Age:	RIN:
		11	N/A

Provider Name:	Provider Phone #:	Provider Address:
Northern Illinois Academy	847.391.8000	998 Corporate Blvd.

Provider City:	Provider State:	Provider Zip Code:	Is the child his/her own guardian? ☐ Yes ☒ No *(If yes, skip the parent/guardian/caregiver section)*
Aurora	IL	60502	

Name of Child's Parent/Guardian/Caregiver:	Parent/Guardian/Caregiver Phone #:	Parent/Guardian/Caregiver Email: ☐ N/A
John Jones - guardian	541-285-7178	john.m.jones@dhsoha.state.or.us

Parent/Guardian/Caregiver Address:	City:	State:	Zip Code:
1899 Willamette St.	Eugene	OR	97401

2. DATE AND TIME OF INCIDENT

Date: 8.25.19 **Start Time:** 7:51 ☐AM ☒ PM **End Time:** ☐AM ☐ PM

3. DATE/TIME/AGENCY SUBMISSION

Date: 8.26.19

Time: ☐ AM ☐ PM

Please identify what notifications have been made. (*Check all that apply*)

☐ Law Enforcement ☒ DCFS ☒HFS ☒ Equip for Equality ☐DHHS/CMS *(death only)*

☐ Other (*describe*)

4. TYPE OF INCIDENT

Please identify what type of critical incident is being reported. *(Check all that apply)*

☐ Abuse/Neglect ☐ Death ☐ Elopement ☐Interface w/ Law Enforcement ☐ Restraint ☐ Seclusion ☐ Serious Injury

☐ Serious Medical Condition ☐ Sexual Aggression ☐ Suicide Attempt ☐ Victimization ☒Other ER visit

4.a. Complete the following section if a restraint or seclusion was used. ☒ N/A

Staff authorizing restraint/seclusion:	Time of order: ☐AM ☐ PM	Name of staff receiving order:	Time received: ☐AM ☐ PM

Were there any injuries to the child as a result of the use of restraint/seclusion? ☐ Yes ☐ No If yes, describe:

Was the physical/psychological health of the child reviewed post-restraint/seclusion? ☐ Yes ☐ No

Time of physical/psychological review completion:

Time: ☐AM ☐ PM

Name of staff completing physical/psychological health review:

Number of Restraints	Restraint Type	Length of Restraint(s)
1.	1.	1.
2.	2.	2.
3.	3.	3.

Place of Seclusion	Seclusion Length	Staff Monitoring Seclusion
1.	1.	1.
2.	2.	2.
3.	3.	3.

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Did a debriefing session occur between staff and the child? ☐ Yes ☐ No Date: Time: ☐AM ☐ PM	**Did a debriefing session occur between all staff involved in the incident?** ☐ Yes ☐ No Date: Time: ☐AM ☐ PM

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

First and Last Name:	**Role in the Incident:**
1.NA	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

Name: Debra Lipman, LCPC	**Title:Director of Compliance and Quality**	**Phone #: 630.952.2229**	**Email: debra.lipman@sequelyouthservices.com**

9. INCIDENT NARRATIVE

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

Resident was struggling throughout the day including an altercation with a peer. Requested to transition to her room, resident began kicking staff. Resident was escorted to her room where she grabbed a staff's member's leg while resident sat on the floor. Staff lost their balance; as a result staff's shin came into contact with resident's nose which began to bleed. Nursing was called to the unit and was able to stop the bleeding. NIA's pediatrician was contacted and resident was transported to the local ER for evaluation. Resident returned to NIA – no fracture indicated. Nursing will continue to monitor.

10. CURRENT STATUS OF CHILD

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

nursing will continue to monitor

☐ Attachments: ____

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HFS OFFICE USE ONLY

Date Received: _____ Reviewer Name:_____ Date Reviewed:_____

Referred to Department of Public Health? ☐ Yes ☐ No Date Referred:_____

☐ Attachments: ____