LDSS-3123 (Rev. 4/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INCIDENT REPORT (DARC)(DAS)

FACILITY NAME:

COUNTY:

INCIDENT CLASSIFICATION:

- ☐ Suicide
- ☐ Sudden Death
- ☐ Accidental Death
- ☐ Abuse of Resident
- ☐ Homicide (or attempt)
- ☐ Assault
- ☐ Resident Fight
- ☐ Leave for more than 24 hours
- ☐ Accidental Injury
- ☐ Work Related Injury
- ☐ Serious Drug Reaction
- ☐ _____

PERSONS INVOLVED	RESIDENT	STAFF	PERSONS INVOLVED	RESIDENT	STAFF
1.	☐	☐	3.	☐	☐
2.	☐	☐	4.	☐	☐

INCIDENT DESCRIPTION: Include injuries, type of first aid given, and employee involvement, attach separate statement of participants and any witnesses. Allow resident to provide their description.

NOTIFICATION GIVEN TO	YES	NO	DATE	NOTIFICATION GIVEN TO	YES	NO	DATE
PHYSICIAN:	☐	☐	/ /	NYS OCFS	☐	☐	/ /
POLICE:	☐	☐	/ /	Local Department of Social Services	☐	☐	/ /
RESIDENT REPRESENTATIVE:	☐	☐	/ /		☐	☐	/ /

OPERATOR'S SIGNATURE:	DATE: / /	RESIDENT'S SIGNATURE	DATE: / /

ACTION TAKEN: Describe medical treatment and/or other corrective actions taken, Include identification of persons or agencies providing care and location where care was provided. Give the current status of the person(s) involved.

ADMINISTRATION/OPERATOR SIGNATURE:	DATE:

RESIDENT: The operator is required by law to include your version of the incident or accident, unless you object or decline. Use the space below for your comments, or if you do not wish to comment, check the box below.

Resident Description of Incident or Accident:

☐ I do not wish to comment.

RESIDENT SIGNATURE:	DATE: