Print form

Form OMR 147 Revised 8/07
For additional guidance in completing this form please see line by line instructions.

State of New York
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

1. AGENCY COMPLETING THIS FORM

REPORTING FORM:
Reportable Incident
Serious Reportable Incident
Allegation of Abuse

2. FACILITY

3. PROGRAM TYPE

4. FACILITY ADDRESS

5. PHONE
( )

6. INCIDENT/ALLEGATION REFERENCE NUMBER

7. WAS AN OMR 147 PREVIOUSLY SUBMITTED?
1 ☐ YES 2 ☐ NO

TO BE COMPLETED BY STAFF DESIGNATED IN POLICY

8. NAME OF PERSON RECEIVING SERVICES (Last, First)

9. DATE OF BIRTH

10. GENDER
1 ☐ MALE
2 ☐ FEMALE

11. I.D. NO

12. DATE & TIME INCIDENT/ALLEGED ABUSE WAS:
1 ☐ Observed
2 ☐ Discovered
MO. DAY YR. HR. MIN. ☐ AM ☐ PM

13. DATE AND TIME INCIDENT/ALLEGED ABUSE OCCURRED (IF KNOWN)
MO. DAY YR. HR. MIN. ☐ AM ☐ PM

14. PRELIMINARY CLASSIFICATION (X ONE)

REPORTABLE INCIDENT
1 ☐ Injury
2 ☐ Death (Also file QCC 100)
3 ☐ Medication Error
4 ☐ Sensitive Situation

SERIOUS REPORTABLE INCIDENT
1 ☐ Injury
2 ☐ Missing Person
3 ☐ Death (Also file QCC 100)
4 ☐ Restraint
5 ☐ Medication Error
6 ☐ Possible Criminal Act
7 ☐ Sensitive Situation

ALLEGED ABUSE
1 ☐ Physical Abuse
2 ☐ Sexual Abuse
3 ☐ Psychological Abuse
4 ☐ Seclusion
5 ☐ Unauthorized or Inappropriate Use of Restraint
6 ☐ Unauthorized or Inappropriate Use of Aversive Conditioning
7 ☐ Unauthorized or Inappropriate Use of Time-Out
8 ☐ Violation of a Person's Civil Rights
9 ☐ Mistreatment
10 ☐ Neglect

15. SPECIFIC LOCATION WHERE INCIDENT/ALLEGED ABUSE OCCURRED
1 ☐ Living Room
2 ☐ Bedroom
3 ☐ Kitchen
4 ☐ Bathroom
5 ☐ Hallway
6 ☐ Staircase
7 ☐ Dining Room
8 ☐ **Program Room**
9 ☐ Recreation Area
10 ☐ **Off-Facility Property**
11 ☐ Unknown
12 ☐ Vehicle
13 ☐ Other *(Specify)* _____

16. BRIEF DESCRIPTION OF THE INCIDENT/ALLEGED ABUSE:

(Continue on separate sheet if necessary)

17. LIST ALL THE IMMEDIATE CORRECTIVE/PROTECTIVE ACTIONS THAT HAVE BEEN TAKEN TO SAFEGUARD THE INDIVIDUAL. THIS SHOULD INCLUDE, BUT IS NOT LIMITED TO, ANY FIRST AID, MEDICAL/DENTAL TREATMENT OR COUNSELING PROVIDED.

(Continue on separate sheet if necessary)

18. REFERRAL TO ADULT PROTECTIVE SERVICES:
1 ☐ YES 1a ☐ Referral accepted 1b ☐ Not accepted 1c ☐ Unknown 2 ☐ NO 3 ☐ N/A

18a. REFERRAL TO STATE CENT. REG. OF CHILD ABUSE AND MALTREATMENT:
1 ☐ YES 1a ☐ Referral accepted 1b ☐ Not accepted 1c ☐ Unknown 2 ☐ NO 3 ☐ N/A

19. PERMANENT RESIDENTIAL ADDRESS AND PHONE NUMBER (of person listed in #8 above, if different than #2 and #5 above)

20. DDSO

21. TYPE OF RESIDENCE
1 ☐ SOIRA 2 ☐ VOIRA 3 ☐ SOICF 4 ☐ VOICF 5 ☐ FC 6 ☐ DC 7 ☐ CR 8 ☐ Other: (*Specify)* _____

22. TEMPORARY RESIDENTIAL ADDRESS AND PHONE NUMBER (if applicable, of person listed in #8 above)

23. PRINT NAME OF PARTY COMPLETING FORM	TITLE	SIGNATURE	DATE
24. PRINT NAME OF PARTY REVIEWING FORM	TITLE	SIGNATURE	DATE

25. DDSO DIRECTOR/AGENCY CHIEF EXECUTIVE OFFICER OR DESIGNEE WAS NOTIFIED OF SITUATION
1 ☐ YES 2 ☐ NO
DATE