

PBIS Incident Form

Individual's Name _____ **Program** _____ **Time** _____

Date _____ **Day** _____ **Reporting Staff** _____

RESIDENTIAL - LOCATION (Check One)

- | | |
|--|--|
| <input type="checkbox"/> Bathroom | <input type="checkbox"/> Kitchen |
| <input type="checkbox"/> Bedroom - Individuals | <input type="checkbox"/> Laundry room |
| <input type="checkbox"/> Bedroom - Peers | <input type="checkbox"/> Living Room |
| <input type="checkbox"/> Basement | <input type="checkbox"/> Outside/parking lot |
| <input type="checkbox"/> Community | <input type="checkbox"/> Van |
| <input type="checkbox"/> Dining room | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fitness room | |

DAY SERVICES - LOCATION (Check One)

- | | | |
|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Bathroom | <input type="checkbox"/> Outside/parking lot | <input type="checkbox"/> Pgrm room 2 |
| <input type="checkbox"/> Community | | <input type="checkbox"/> Pgrm room 3 |
| <input type="checkbox"/> Kitchen | <input type="checkbox"/> Program area | <input type="checkbox"/> Pgrm room 4 |
| <input type="checkbox"/> Fitness room | <input type="checkbox"/> Sensory Room | <input type="checkbox"/> Van |
| <input type="checkbox"/> Lockers | <input type="checkbox"/> Day Hab 1/2 door | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Office | <input type="checkbox"/> PG1 | |

PROBLEM BEHAVIORS/ INCIDENTS (Check One - Most Serious)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Abusive/Inapp. language | <input type="checkbox"/> Harassment/bullying | <input type="checkbox"/> Physical altercation | <input type="checkbox"/> Tantrum (Phys Agg/SIB/prop destruction) |
| <input type="checkbox"/> Disruptive | <input type="checkbox"/> PICA | <input type="checkbox"/> Physical aggression | <input type="checkbox"/> Verbal threats |
| <input type="checkbox"/> Eloping | <input type="checkbox"/> Inapp. Sexual behavior | <input type="checkbox"/> Property damage | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fall/injury | <input type="checkbox"/> Medication Refusal | <input type="checkbox"/> Smearing (fecal/urine) | |
| | <input type="checkbox"/> Non-compliance | <input type="checkbox"/> Self-Injurious Behavior | |

PERCEIVED MOTIVATION (Check one)

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Obtain Staff Attention | <input type="checkbox"/> Obtain Sensory | <input type="checkbox"/> Avoid Task/Activity | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Obtain Peer Attention | <input type="checkbox"/> Avoid Staff Attention | <input type="checkbox"/> Avoid Sensory | |
| <input type="checkbox"/> Obtain Item/Activity/Location | <input type="checkbox"/> Avoid Peer Attention | <input type="checkbox"/> Unknown Motivation | |

ANTECEDENT (Check One)

- | | | |
|--|--|---|
| <input type="checkbox"/> Challenging task | <input type="checkbox"/> New/changed environment | <input type="checkbox"/> Stranger interaction |
| <input type="checkbox"/> Changed routine | <input type="checkbox"/> Peers interaction | <input type="checkbox"/> Transition |
| <input type="checkbox"/> Home visit | <input type="checkbox"/> Prior incident | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Medical issue | <input type="checkbox"/> Staff interaction | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Staff request | <input type="checkbox"/> Denied Item/Activity |
| <input type="checkbox"/> Noisy environment | | <input type="checkbox"/> Other _____ |

PROACTIVE STRATEGY

(✓ all that apply)

- | |
|---|
| <input type="checkbox"/> Verbal/gestural/visual Redirection |
| <input type="checkbox"/> Remove Object |
| <input type="checkbox"/> Remove Audience |
| <input type="checkbox"/> Blocking |
| <input type="checkbox"/> Physical Redirection |
| <input type="checkbox"/> Other _____ |

OTHERS INVOLVED

(Check all that apply)

- | |
|--------------------------------------|
| <input type="checkbox"/> Staff |
| <input type="checkbox"/> Peers |
| <input type="checkbox"/> Family |
| <input type="checkbox"/> Manager |
| <input type="checkbox"/> Other _____ |

INJURY

(✓ all that apply)

- | |
|--------------------------------------|
| <input type="checkbox"/> Peer |
| <input type="checkbox"/> Staff |
| <input type="checkbox"/> Self |
| <input type="checkbox"/> Other _____ |

ADMINISTRATIVE ACTION

(Check all that apply)

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Contact Manager | <input type="checkbox"/> Comm. Log |
| <input type="checkbox"/> Contact Director | |
| <input type="checkbox"/> Contact Guardian | |
| <input type="checkbox"/> Property Damage Resolved | |
| <input type="checkbox"/> DDS Incident report/HCSIS | |
| <input type="checkbox"/> Other _____ | |

EMERGENCY ACTION

(Check all that apply)

- | | |
|---|---------------------------------|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Police |
| <input type="checkbox"/> Contact Nurse | <input type="checkbox"/> Fire |
| <input type="checkbox"/> Doctor Visit/Urgent Care | |
| <input type="checkbox"/> ER Visit | |
| <input type="checkbox"/> Hospital Admission | |
| <input type="checkbox"/> Emergency Restraint | |
| <input type="checkbox"/> Other _____ | |

Brief Description of Incident:
