SEDGWICK COUNTY DISABILITY ORGANIZATION
CRITICAL INCIDENT REPORT

Clear Form

Please complete this form in its entirety

Agency Completing Form:

Notification Date:

Date of Incident:

Name of Person Receiving Services:

Day Service Provider:

Residential Service Provider:

Residential Address:

Personal Care Service Provider:

TCM Service Provider:

TCM Name:

Service Received During Incident:

This form will be sent to the CDDO Incident Report inbox (cddoincidentreports@sedgwick.gov).

☐ Adverse Incident Report submitted.

Must select at least one of the following categories below to complete additional information:

☐ **Suspected or known incident of potential physical harm, neglect, mental/emotional harm, sexual abuse, exploitation, theft or exploitation of money or possession.**

☐ **Contact with Emergency Medical, including Hospitalizations and Scheduled Surgeries.**

☐ **Contact with Law Enforcement or Security (including involvement as victim or perpetrator) or contact with Fire Department.**

☐ **Other required reportable incident.**

☐ **Miscellaneous incident CSP believes should be reported or high profile incident which could be reported to the news.**

Summary of the Incident:	
Follow Up (Dates and Narrative):	

Message	
Subject	
CC	
To	cddoincidentreports@sedgwick.gov

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