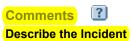
Logged on

102956

SIR - Special Incident Report (* = Required)

		_		
Incident Details				
,	Vendor:	SOUTHERN CAL	LIFORNIA FOSTER FAMIL	Y AGENCY (102956) - FF
Lic	ense #:	191500291 - SOUT	HERN CALIFORNIA FOSTER FA	MILY AGENCY 🛊
		(Select)	•	
Certified Paren	t Name:			
		Last Name:	First Name:	
Facility A	ddress:			
Incide	nt Date:		(mm/dd/yyyy) (ncident	Date Unknown
Incider	nt Time:		☐ Incident Time Unknowr	1
Location of In	ncident:	(Select)	*	
Incident Types ?				
Behavioral/Mental Health I	ncident _	Self Injurious Behavior	Hospitalization(Medical)	Sexual
Assaultive Behavior(Car	egiver)	Staff Related	Hospitalization(Psychiatric)	☐ Verbal/Emotional
Assaultive Behavior(Pee	<mark>er)</mark>	Substance Abuse	Death	Agency Emergency/Disaster
Assaultive behavior (Oth	i <mark>er)</mark>	Suicidal Ideation	Death	Earthquake Damage
Inappropriate Sexual Be	<mark>havior</mark>	Suicide Attempt	Unauthorized Absence	Epidemic
Medical Related		Theft	Abduction	Explosion
Physical Restraint	<mark>lnj</mark> i	ury, Illness or Accider	nt Run Away	☐ Fire
Police Involvement		Accident	Child Abuse	Flood
Property Damage		Illness	□ Neglect	Other
Seclusion		Injury	Physical Physical	Other Other
Foster Children Involv	ved:			
Others Involved				
Add Person ?				
Child - DOB Clear S Click the "Add Perso selected child into th	n" buttor	ı to insert -	or - New Person 🔲 o	ut of county child
			Last Name:	First Name:
			Birth Date:	State ID:
	Ho	w is this person invol	ved: (Select) ♦	
		Add Per	rson	



Describe the Injuries Sustained and Care Giv	en/Medical Intervention		
,			
Conclusions/Action Taken			
Reporting Parties			
Name of staff making report:	*		
Title:	*	-	
Telephone:	* Ext. Please use digits only for phone n	umber	
Our and as Barranto (If Applicable)	Thouse doe digite only for phone in		
Supervisor Remarks(If Applicable)			
Name of Supervisor:	*		
Title:	*		
	* Ext.	1	
Telephone:	Please use digits only for phone n	umber	
Cross Reports ?			
Cross Reports 2			
Add Cross Report			
Date/Tin	16		CWS
Report To Reported		Contact Name	Referral No
	(Select) 💠		1
(Select) * (mm/dd/yyyy	*	*	Add Cross Report
hh:mmAM/P If the youth is a DMH client, please print out the SIR	M)	orm. Please click here	if you need a copy of the DMH form (clos
the DMH form after you print form).			
Other Reports (If Applicable. Per DMH, DO NO	OT include reference of DMH fo	orm in this section.)
Save	Submit	Clear	

Redesigned, re-engineered and developed By ITS team of DCFS, Los Angeles County
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