

State of New Jersey
Department of Military and Veterans Affairs
Division of Veterans Healthcare Services
UNUSUAL INCIDENT - SENTINEL EVENT REPORT

Complete all information when reporting Incidents/Events.

Fax to **Division Director's Office 1-(609)-530-6970** Monday through Friday from 8:30 a.m. to 4:30 p.m.

For Category "A" emergencies, call 1-(609)-530-6967

Sentinel Events to VA Jurisdiction – EOVA (973)-667-1000, ext 1770 - Fax (973)-395-7033

Wilmington, DE. VA (302)-633-5420, 1-800-461 - 8262, Ext 5420, Fax (973)-395-7003

CONFIDENTIAL

Facility: _____ Incident Category: A _____ B _____ **Sentinel Event** : _YES_____NO_____

Name of person involved: _____ Case No: _____ Age: _____

Room No.: _____ Address if appropriate: _____

Status of Individual Involved: _____ Resident _____ Employee _____ Visitor _____ Other, Explain _____

Place of Incident: _____ Date: _____ Time: _____ a.m. _____ p.m. _____

NOTIFICATIONS:

CEO	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
ACEO	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
Dept. Head	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
Safety Officer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
Next of Kin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
Legal Guardian	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
Autopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
Facility Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
Police	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
Investigated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Time _____ (am/pm)
Veterans Healthcare Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Name _____
N.J. Dept. of Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Name _____
Ombudsman's Office	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Name _____
Div. of Drug Control			
Alcohol/Narcotic Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Name _____
Bur. of Profession/Occupations,			
Dept. of Law & Safety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Name _____
VA of Jurisdiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Name _____
Other Agencies Notified List	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____	Name _____

Property Damage Yes No Describe: _____

Personal Injuries Yes No Describe: _____

Diagnosis & Treatment (for Internal Use Only): _____

Treating Physician: _____

Personnel on Duty: _____

Personal Injuries Yes No Describe: _____

Actions to be Taken: _____

