Louisiana Department of Health and Hospitals

Hospital Abuse/Neglect Initial Report

Fax Completed Form to (225)342-0157 within 24 Hours of Awareness of Allegation

White boxes *that allow free text* will automatically expand to fit entire entry.
You may enter all information on this form; it will automatically add pages as necessary.
LABEL ALL PAGES WITH HOSPITAL NAME ✷ PLEASE DO NOT WRITE IN SHADED AREAS

Type of Incident	☐	Alleged Sexual Abuse	☐	Alleged Physical Abuse
	☐	Alleged Neglect	☐	Other

Hospital and Contact Information

Name of Hospital:		**Hospital License #:**	
Address of Hospital (Main Campus):			
Name of Administrator/CEO:		**Administrator Phone #:**	
Administrator Email:		**Administrator Fax #:**	
Name, Title, & Position of Employee Submitting This Report:			
Submitter's Phone #:		**Submitter's Email:**	

Incident Information

Date of Incident (If Known):		**Time of Incident (If Known):**		**Shift of Incident:**	
Date of DISCOVERY:		**Time of DISCOVERY:**		**Shift of DISCOVERY:**	
General Location of Incident:	☐ **Main Campus**	☐ **Licensed Offsite**	☐ **Other (Indicate Location Below)**		
"Other" Location Description:					
Specific Location of Incident (Unit, Room):					

Patient Information (Include *all* patients directly involved)

Name	Date of Birth	Admit Date	D/C Date	Admitting Diagnoses

Alleged Perpetrator Information (NOTE: Patients are *never* to be listed in this section)

Name	Title	Date of Hire	Social Security #	Professional License #

Video Surveillance

Video surveillance at incident site?	☐	**YES**	☐	**NO**	**Is video recorded?**	☐	**YES**	☐	**NO**	☐	**N/A**
If recorded, how long is recording maintained?					**Has video been reviewed?**	☐	**YES**	☐	**NO**		
If video was *not* reviewed, why not?											
Names, Titles, and Positions of all Video Reviewers:											
What was revealed on video?											

Name or Signature and Title of Preparer

Date

Name of Hospital:		**Date of Incident:**	

Incident Details

Was Patient Still Hospitalized When Allegation Became Known to Hospital?	☐	**YES**	☐	**NO**	☐	**Unknown**	
How Was Incident Discovered?	☐	**Patient Reported**	☐	**Staff Member Reported**	☐	**Family/Other Reported**	
Did the Initial Reporter Claim to Witness the Incident?	☐	**YES**	☐	**NO**	☐	**Unknown**	

Name, Title, & Position of the First Employee Aware of Allegation AND *HOW THEY BECAME AWARE OF ALLEGATION:*

Describe the alleged incident (include as much detail as possible):

Name, Title, & Position of Clinician that Assessed Patient(s):							
Date Assessed:		**Time Assessed:**		**Were X-Rays or Other Tests Done?**	☐	**YES**	☐ **NO**

List X-Rays and any other tests conducted *AND RESULTS* (if known):

Did the Patient(s) sustain apparent injuries or adverse effects in relation to the incident?	☐	**YES**	☐	**NO**

Describe injuries and/or adverse effects *AND TREATMENT PROVIDED*:

Initial Actions Taken (Describe Immediate Actions Taken to Safeguard Patients)

Notification (Please include Hospital Personnel notified as well as outside entities)

Were the following notified?

Physician	☐	**YES**	☐	**NO**	**Date/Time Notified:**		**Name of Physician:**		
Family	☐	**YES**	☐	**NO**	**Date/Time Notified:**		**Name/Relationship:**		
Police	☐	**YES**	☐	**NO**	**Date/Time Notified:**		**Name of Law Enforcement Agency:**		
Was an officer dispatched to the hospital?	☐	**YES**	☐	**NO**	**Officer's Name:**				
Licensing Board *(Not DHH)*	☐	**YES**	☐	**NO**	**Name of Board:**				
Board Personnel Receiving Report (Name/Title):					**Date/Time Notified:**				
How was Licensing Board notified?	☐	**Telephone**	☐	**Email/Website**	☐	**Written**	☐	**Other**	

Hospital Personnel Notified (In order of notification – begin with 1st staff member aware of event/allegation):

Name	Title	Position/Role	Date Notified	Time Notified

Comments:

Name or Signature and Title of Preparer

Date