

OSU TFC REPORT

(To be submitted within 24 hours of event. Fax to 599-5699)
(Must fill out for all injuries to head, neck, abdomen, and groin area)

Child: _____ Parent: _____ Therapist: _____

Location of Event: _____ Date ____/____/____ Time: ____:____:____

Type of report: (check appropriate category)

- | | | |
|--|--|--|
| <input type="checkbox"/> Threats to Inflict Harm | <input type="checkbox"/> Suspension from School | <input type="checkbox"/> Alleged Sexual Perpetration |
| <input type="checkbox"/> Physical Aggression | <input type="checkbox"/> Truancy from School | <input type="checkbox"/> Alleged Sexual Victimization |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Self Inflicted Injury | <input type="checkbox"/> Behavior requiring DHS Hotline Notification |
| <input type="checkbox"/> Damage to Property | <input type="checkbox"/> Dangerous disregard for rules/policy | <input type="checkbox"/> CPI Restraint |
| <input type="checkbox"/> Theft | <input type="checkbox"/> Runaway/AWOL Behavior | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Drug/Alcohol Use | <input type="checkbox"/> Illness/Injury | |
| <input type="checkbox"/> Contact with the Law | <input type="checkbox"/> Illness/Injury requiring Medical Care | |
| <input type="checkbox"/> Behavior Requiring Police Involvement | | |

Witnesses: _____

Preventative measures taken: _____

Persons Involved: _____

Description of Event (include what led up to event): _____

If needed use back for more information/details

Action/Intervention/Resolution: _____

Signature & Title of person completing report: _____ Date: ____/____/____

Notification Type Phone Page Written Fax None
Who Notified: Therapist CW Worker CW Liaison Secondary CW Worker Other _____
Name(s) _____ Date Notified: ____/____/____ Time: ____:____:____ AM/PM

Name(s) _____ Date Notified: ____/____/____ Time: ____:____:____ AM/PM

For Staff Use ~~~~~For Staff Use ~~~~~For Staff Use ~~~~~For Staff Use ~~~~~For Staff Use ~~~~~For Staff Use

Notification Type Phone Fax Hotline None Needed
Notified: CW Worker CW Liaison Secondary CW Worker Co Director Other _____
Name(s) _____ Date Notified: ____/____/____ Time: ____:____:____ AM/PM

Name(s) _____ Date Notified: ____/____/____ Time: ____:____:____ AM/PM

Follow-Up (interventions, additional suggestions, recommendations, preventions, etc.): _____

Therapist Signature _____ Date _____ Director _____ Date _____