**Name of Reporting Agency:**

**Program Name:**

**Location/Address of Incident: When did the incident occur?**

**Date: Time:**

**Address: City: State: Zip:**

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap to enter a date.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

**Setting** **Residential Type of Incident**

**OMHC  OTS  Level 3.1  Death**

**PRP  IOP 2.1  Level 3.3  Serious Bodily Inj.**

**RRP  OP Level 1  Level 3.5  Fire**

**Care Coordination/Targeted Case Mgmt.**  **Level 3.7**   **Suicide**

**Partial Hospitalization Treatment Level 2.5**

**Psychiatric Day Treatment Program  Level 3.7D  Suicide Attempt**

**Mobile Treatment Services Program  Homicide**

**Group Home  Elopement**

**Integrated Behavioral Health Program  Missing Person  Assault  Medication Error  Seclusion/Restrict Other:**

**Consumer/Alleged Victim**

**First Name: Middle Name: Last Name:**

**Date of Admission: Sex: Age: Race:**

**Address: City: State: Zip:**

**Alleged Perpetrator**

**First Name: Middle Name: Last Name:**

**Date of Admission: Sex: Age: Race:**

**Address: City: State: Zip:**

**Behavioral Health Diagnosis Medical Diagnosis**

**Primary Primary**

**Diagnosis Diagnosis**

**Diagnosis Diagnosis**

**Medications**

1. **4.**
2. **5.**
3. **6.**

**Endangered Adult or Child Notification Made:**

**Adult** **Protective Services (APS)  Yes**  **No  N/A**

**Child Protective Services (CPS)  Yes  No  N/A**

**Date Notified:**

**Law Enforcement Contact:**  **Yes  No Hospitalization:  Yes  No**

**EMT:  Yes  No**

**Consumer Status:**

**Date last seen for service:**

**Precautions prior to this incident:**

**Precautions initiated after incident:**

**Significant medical history:**

**Medication changes in the last 90 days  Yes  No**

**Services Received:**

**Individual Therapy  Group Therapy  Medication Management**

**Case Management  ACT/Mobile Crisis  Detoxification/inpatient/outpatient**

**Other (Specify):**

**Last Date of Service: Type of Service:**

**Description of Event/Incident(s):**

***Instructions*: Please write a detailed concise description that took place including any significant events that led up to the incident. Specify names of those involved including staff related to the event/incident.**

**Incident Resolution and/or Agency Plan of Action**

**Will there be an internal review of this incident by this agency?  Yes  No**

**Name of Person Completing Form:**

**First Name: Last Name: Date:**

**Title:**

**(Include credentials, if applicable)**

**Email:** **Phone: Fax:**

**Name of Agency Contact for Follow-up:**

**First Name: Last Name: Date:**

**Title:**

**(Include credentials, if applicable)**

**Email: Phone: Fax:**

**Reviewed by BHSB: Name: Date:**