**Name of Reporting Agency:**

**Program Name:**

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

 **Date: Time:**

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

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

**OMHC OTP Death Elopement**

**PRP IOP Serious Bodily Injury Missing Person**

**RRP OP Fire Assault**

**Care Coordination/Targeted Case Mgmt. Suicide Medication Error**

**Early Intervention Suicide Attempt Seclusion/Restrict**

**Residential Homicide Other**

**Level 3.1**

**Level 3.3**

**Level 3.5**

**Level 3.7**

**Level 3.7D**

**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 Contract:**  **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:**

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

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

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

**Title:**

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

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