**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:**