

Confidential Incident Report

Today's Date: _____ Date of Incident: _____ Time of Incident: _____

Person filling report: _____ Phone Number: (____) _____

Person(s) involved in incident: _____

Patient Name: _____ Patient ID: _____

Patient Phone (home): (____) _____ & (Work): (____) _____

Type of Risk: Injury Adverse Incident Medical Emergency - Location of Incident: _____

<p>Type of Occurrence:</p> <p><input type="checkbox"/> Injury</p> <p><input type="checkbox"/> Medical Emergency</p> <p><input type="checkbox"/> Other (describe)</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Type of Adverse Incident:</p> <p><input type="checkbox"/> Suicide Attempt</p> <p><input type="checkbox"/> Ideation with plan or intent verbalized</p> <p><input type="checkbox"/> Suicide</p> <p><input type="checkbox"/> Other (describe)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Description of incident in narrative form (use separate page if additional space is required):

Network Clinicians Actions: (check all those taken)

Called Police/911 Psychiatric Consultation arranged with _____

Hospitalized Notified Other Providers of care: (whom) _____

Involved Family Member/Friend: _____ Who has agreed to: _____

Contracted for Safety Emergency Contact Procedures Discussed Other: _____

If Patient Death Occurred Date Informed: _____ By Whom: _____

Resolution:

Arranged for items to be removed from patient's home Patient contracted for safety Follow-up arranged

Signature: _____ **Date:** _____

Please fax completed form to: Attn: Compliance 866-694-3730