



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

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

Person(s) involved in incident: _____

Address/City/State/Zip where occurred: _____

Patient Name: _____ Patient ID: _____

Patient Phone (Home) (_____) _____ & (Work) (_____) _____

Type of Risk: Injury Adverse Incident Medical Emergency

Type of Occurrence: <input type="checkbox"/> Injury <input type="checkbox"/> Medical Emergency <input type="checkbox"/> Police called/911 <input type="checkbox"/> Other (describe) _____ _____ _____	Type of Adverse Incident: <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Ideation with plan or intent verbalized <input type="checkbox"/> Suicide <input type="checkbox"/> Assault <input type="checkbox"/> Other (describe) _____ _____ _____
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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 procedure 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: _____

For CBH Staff use only: <input type="checkbox"/> Potential Quality Issue <input type="checkbox"/> Patient placed in High Risk Management Program If yes, date sent to legal _____ / _____ / _____	<input type="checkbox"/> Quality of Care Form Completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Legal Risk Assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> QI Director notified <input type="checkbox"/> Medical Director notified <input type="checkbox"/> Operations notified
Cenpatico Staff Signature _____	Date: _____