St. Clair County Community Mental Health Authority

OFFICE OF RECIPIENT RIGHTS

Incident Report

Recipient's Initials:	Case #:
Incident Date:	Incident Time:
Location of Incident: _____ Street Address: _____ City: _____ State: _____ Zip Code: _____	Responsible Provider Agency: _____ Responsible Staff #1: _____ Responsible Staff #2: _____ Responsible Staff #3: _____ Supervisor of Responsible Staff: _____

CHECK TYPE OF INCIDENT & PROVIDE ADDITIONAL INFORMATION, if requested

- ☐A. Abuse or Neglect (Apparent or Suspected) If regarding a staff member, a recipient rights complaint must be filed
- ☐B. Arrest or Incarceration — Charge/Length of Incarceration/Facility: _____
- ☐C. Assaulted by Peer/Other — If injury occurred, provide injury detail: _____
- ☐D. Behavior with Injury/without Injury — If injury occurred, provide injury detail: _____
- ☐E. Death of Recipient — Cause of Death: _____
- ☐F. Elopement — Law Enforcement Contacted by: _____
- ☐G. Emergency Medical Treatment — Treatment Provided by: _____
- ☐H. Fall/Accident — If injury occurred, provide injury detail: _____
- ☐I. Hospitalization due to Illness/Injury — Facility & Diagnosis: _____
- ☐J. Hospitalization due to Medication Error — Facility & Diagnosis: _____
- ☐K. Hospitalization due to Psychiatric Concern — Name of LPH/U: _____
- ☐L. Law Enforcement Involvement — Contacted by: _____
- ☐M. Physical Aggression/Property Destruction — Describe aggression/destruction: _____
- ☐N. Physical Management — Technique: _____ Length of Time: _____
- ☐O. PRN Medication for Behavior Control — Name of Medication Administered: _____
- ☐P. Program Suspension — Violation/Length of Suspension: _____
- ☐Q. Suicidal Ideation/Threat/Action — Immediately notify your supervisor and the recipient's case holder for direction
- ☐R. Unknown Injury/Bruise — Describe injury/bruise: _____
- ☐S. Verbal Aggression (to include use of swear words/threatening language)
- ☐T. Other: _____

Description of Incident: _____

_____

Persons Notified: _____

Reporting Staff Signature: _____

Date Report Completed: _____ **Time Report Completed:** _____

Supervisor Signature: _____

Date of Supervisor Review: _____ **Time of Supervisor Review:** _____

Corrective Measures Taken to Prevent Recurrence: _____
_____

OFFICE OF RECIPIENT RIGHTS REVIEW of INCIDENT

ORR Staff Initials: _____ **Date:** _____ **Time:** _____

Comments/Action Required: _____