St. Clair County Community Mental Health

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: ____

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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: ____
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OFFICE OF RECIPIENT RIGHTS REVIEW of INCIDENT

ORR Staff Initials: ________________ **Date:** ________________ **Time:** ________________

Comments/Action Required: ____