ALLEGAN COUNTY COMMUNITY MENTAL HEALTH SERVICES
INCIDENT REPORT

AGENCY INFORMATION		
Agency Name:	Unit Name/ Service	Phone Number:

RECIPIENT INFORMATION			
Recipient Name:	☐ Male ☐ Female	Date of Birth:	CMH Case Number:

INCIDENT INFORMATION		
When did you discover incident? Date: Time: ☐AM ☐ PM	When did incident happen? Date: Time: ☐AM ☐ PM	Where did incident happen?

OTHER PERSONS INVOLVED/ WITNESSES	***Do not include recipient full names (use client ID or initials only)***		
Name	☐ Recipient ☐ Employee ☐ Visitor	Name	☐ Recipient ☐ Employee ☐ Visitor
Name	☐ Recipient ☐ Employee ☐ Visitor	Name	☐ Recipient ☐ Employee ☐ Visitor

Explain What Happened (Include relevant precursors/injury to the individual/any injury to others):

Action Taken by Staff (Include Intervention used/ 911 Calls /Medical Treatment Received):

Reporting Person's Name (PRINT)	Reporter's Title
Reporting Person's Signature	Date and Time of Report ☐AM ☐ PM

THIS SECTION TO BE COMPLETED BY DESIGNATED SUPERVISOR:	
Corrective Measures Taken to Prevent Reoccurrence (Staff training/Contact with Primary Clinician/Requests for Additional Services/Psych Consult/Debriefing):	
Supervisor's Signature	Date

PERSONS NOTIFIED	
Voicemail notification to Office of Recipient Rights: (date & time) ☐AM ☐ PM	Faxed to ACCMHS: (date & time) ☐AM ☐ PM
Guardian/Designated Representative:	Protective Services (if applicable):
Verbal Notification to Supports Coordinator/ Case Manager:	Other:

**Note if Physical Management was utilized, an Emergency Use of Physical Management Form is to be completed and attached.

DISTRIBUTION: 1. Maintain original at agency 2. Fax to ACCMHS at (269) 686-5267

Revised 2/15