

## ONPOINT INCIDENT REPORT

AGENCY INFORMATION		
Agency Name:	Unit Name/ Service	Phone Number:
RECIPIENT INFORMATION		
Recipient Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: CMH Case Number:
INCIDENT INFORMATION		
When did you discover incident? Date: Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	When did incident happen? Date: Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Where did incident happen?
OTHER PERSONS INVOLVED/ WITNESSES <b>***Do not include recipient full names (use client ID or initials only)</b>		
Name <input type="checkbox"/> Recipient <input type="checkbox"/> Employee <input type="checkbox"/> Visitor	Name <input type="checkbox"/> Recipient <input type="checkbox"/> Employee <input type="checkbox"/> Visitor	Name <input type="checkbox"/> Recipient <input type="checkbox"/> Employee <input type="checkbox"/> Visitor
Name <input type="checkbox"/> Recipient <input type="checkbox"/> Employee <input type="checkbox"/> Visitor	Name <input type="checkbox"/> Recipient <input type="checkbox"/> Employee <input type="checkbox"/> Visitor	Name <input type="checkbox"/> Recipient <input type="checkbox"/> Employee <input type="checkbox"/> 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 <input type="checkbox"/> AM <input type="checkbox"/> 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) <input type="checkbox"/> AM <input type="checkbox"/> PM	Faxed to OnPoint: (date & time) <input type="checkbox"/> AM <input type="checkbox"/> 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.		
<b>DISTRIBUTION: 1. Maintain original at agency 2. Fax to OnPoint at (269) 686-5267</b>		

Revised 2/15