North Country Community Mental Health

CLIENT INCIDENT REPORT

Date of Incident **Time** ☐ AM ☐ PM	Program ☐ Day Services ☐ Supported Community Living ☐ Residential ☐ Other
Client Name	**Client ID**
Residence, Site or Program Name	Address
City, State	Phone Number

OTHER PERSON/S INVOLVED/WITNESSES

Name ☐ Employee ☐ Visitor ☐ Client	Name ☐ Employee ☐ Visitor ☐ Client
Name ☐ Employee ☐ Visitor ☐ Client	Name ☐ Employee ☐ Visitor ☐ Client

DESCRIPTION OF THE INCIDENT (Attach additional pages, as needed; include client ID, date of event and reporter's signature)

Describe events leading up to incident, what happened, and any injuries to client or others.

Describe action taken by staff, any treatment given to client, and final outcome to client.

Name of Treating Physician/Health Care/Medical Facility/Hospital	Phone Number	Date Care Given	Time ☐ AM ☐ PM
Physician Diagnosis of Injury, Illness or Cause of Death, if known:			

SIGNATURES

Reporter's Signature	Print Name and Title	Date

COMPLETED BY CONTRACT PROVIDER SUPERVISOR (if applicable) AND NCCMH SUPERVISOR

CORRECTIVE ACTION - CORRECTIVE MEASURES TAKEN TO REMEDY AND/OR PREVENT RE-OCCURRENCE

Provider Supervisor Signature	Print Name and Title	Date
NCCMH Supervisor Signature	Print Name and Title	Date

PERSONS NOTIFIED

NCCMH (Identify CMH Worker)	Date	Adult Protective Services (if applicable)	Date
Physician or RN (if applicable)	Date	Child Protective Services (if applicable)	Date
Parent/Legal Guardian	Date	Office of Recipient Rights **Faxed copy of Incident Report to RRO**	Date
Law Enforcement Agency	Date	AFC/CFC Licensing	Date

TYPE OF EVENT: check ONE

- ☐ Accident - Fall
- ☐ Accident - Vehicle
- ☐ Accident - Other
- ☐ Aggressive Behavior (aggressor)
- ☐ Arrest
- ☐ Choking/Obstructed Airway
- ☐ Criminal Act without Arrest
- ☐ Death
- ☐ Evacuation – Fire
- ☐ Evacuation - Utilities
- ☐ Evacuation – Weather
- ☐ Homicide – Attempt/Threat
- ☐ Illness / Health Issue
- ☐ Inappropriate Sexual Behavior
- ☐ Infection Control Issue
- ☐ Injury - Minor
- ☐ Injury - Serious
- ☐ Injury – Aggression by other
- ☐ Medication – Client Refused
- ☐ Medication – Count Discrepancy
- ☐ Medication – Delay/Missed
- ☐ Medication – Wrong Dose
- ☐ Medication – Wrong Med
- ☐ Medication – Wrong Person
- ☐ Medication – Wrong Route
- ☐ Medication – Wrong Time
- ☐ Medication - Other
- ☐ Other
- ☐ Privacy / Confidentiality
- ☐ Probation/Parole Violation
- ☐ Safety Concern
- ☐ Substance Use
- ☐ Suicide
- ☐ Unauthorized Leave of Absence
- ☐ Victim- Aggressive behavior without physical injury
- ☐ Victim – Sexual assault
- ☐ Victim - Theft

TREATMENT OR OTHER OUTCOME: check ALL that apply

- ☐ Assessed; No Treatment Required
- ☐ First Aid by Staff
- ☐ Physician Appointment
- ☐ Emergency Medical Treatment
- ☐ Hospital Admission
- ☐ 9-1-1 for Police Assistance
- ☐ Physical Intervention Used
- ☐ Behavior Treatment Plan Followed
- ☐ Behavior Treatment Plan Requested
- ☐ Risk Exposure: Clients/Others at risk, but no adverse outcome

**If the event was caused by "harm to self or others", please indicate if the client or other person received ☐ emergency medical treatment or if the client or other person was ☐ hospitalized.

Meets criteria for CQI Indicator Report? ☐ NO ☐ YES: attach copy of this form to CQI Report