CONSUMER INCIDENT, ACCIDENT, ILLNESS, DEATH, OR ARREST REPORT
MACOMB COUNTY COMMUNITY MENTAL HEALTH SERVICES

Facility/Home Facility Code_____	Recipient
Facility Address	Age Sex: M( ) F( )
City Zip	Case Number
Licensee/Organization	Licensee Number

PERSONS INVOLVED/WITNESSED

Name	Name
Address	Address
Phone Number	Phone Number

PERSONS INVOLVED/WITNESSED

Date of Incident:	Time:	Location:

CHECK TYPE OF INCIDENT

A. ☐ Suicide
B. ☐ Death (non suicide)
C. ☐ Use of physical management **(Must also complete and attach Use of Physical Management Form)**
D. ☐ Emergency medical treatment due to injury or physical illness
E. ☐ Hospitalization (Medical) due to injury or physical illness
F. ☐ Property destruction – over $100
G. ☐ Serious display of verbal or behavior hostility
H. ☐ Emergency medical treatment due to medication error **(Must also complete and attach Medication Error Form)**
I. ☐ Hospitalization (Medical) due to medication error **(Must also complete and attach Medication Error Form)**
J. ☐ Suspected adverse reaction to medication **(Must also complete and attach Medication Error Form)**
K. ☐ Staff administration of incorrect medication **(Must also complete and attach Medication Error Form)**
L. ☐ Staff administration of incorrect dosage **(Must also complete and attach Medication Error Form)**
M. ☐ Staff failed to administer medication **(Must also complete and attach Medication Error Form)**
N. ☐ Arrest of consumer
O. ☐ Allegations of, apparent, or suspected abuse and neglect **(Must immediately notify the Office of Recipient Rights at (586) 469-6528 or immediately fax a Recipient Rights Complaint form to (586) 466-4131 for abuse and neglect and all other possible rights violations)**
P. ☐ Other

EXPLAIN WHAT HAPPENED:

ACTION TAKEN BY STAFF/TREATMENT GIVEN [INCLUDING TREATING PHYSICIAN; MEDICAL FACILITY; DIAGNOSIS OR CAUSE OF DEATH]:

ACTION TAKEN TO REMEDY AND/OR PREVENT RECURRENCE OF INCIDENT, ACCIDENT, ILLNESS, DEATH, OR ARREST

PERSONS NOTIFIED (NAME) DATE/TIME	PERSONS NOTIFIED (NAME) DATE/TIME
☐ Adult Foster Care Licensing:	☐ Adult/Children Protective Service:
☐ Physician or RN:	☐ Office of Recipient Rights:
☐ Case Manager/Supports Coordinator:	☐ Law Enforcement:
☐ Supervisor:	☐ Other (Specify):

SIGNATURE OF PERSON COMPLETING REPORT	PRINT NAME AND TITLE	DATE
SIGNATURE OF LICENSEE/ADMINISTRATOR	PRINT NAME AND TITLE	DATE