



Detroit Wayne Integrated Health Network

INCIDENT / ACCIDENT / ILLNESS / DEATH / ARREST / ETC.

Name of Facility/Home	License Number	Name of Resident/Recipient	
Facility Address		MH-WIN Member number	
Facility Phone		Age	Date of Birth
Licensee Name		Sex (circle) <div style="display: flex; justify-content: space-around; width: 100%;"> Male Female </div>	

OTHER PERSON(S) INVOLVED / WITNESSES:

Name <input type="checkbox"/> Resident <input type="checkbox"/> Employee <input type="checkbox"/> Visitor	Name <input type="checkbox"/> Resident <input type="checkbox"/> Employee <input type="checkbox"/> Visitor
Name <input type="checkbox"/> Resident <input type="checkbox"/> Employee <input type="checkbox"/> Visitor	Name <input type="checkbox"/> Resident <input type="checkbox"/> Employee <input type="checkbox"/> Visitor

FACTS OF THE INCIDENT (ATTACH ADDITIONAL PAGES AS NEEDED):

Date of Incident	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Name of Employee Assigned to Resident (if Applicable)	Location of Incident (Kitchen, Yard, etc.)
Explain What Happened / Describe Injury (if any) (Attach separate sheet if necessary):			
Action taken by Staff / Treatment Given (Attach separate sheet if necessary):			
Corrective Measures Taken to Remedy and/or Prevent Recurrence (Attach separate sheet if necessary):			
Name of Treating Physician / Health Care / Medical Facility / Hospital	Phone Number	Date Care Given	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Physician's Diagnosis of Injury, Illness or Cause of Death, if known			

PERSON(S) NOTIFIED:

AFC Licensing	Notification Date / Time Written Notice / Date	Adult Protective Services (if applicable)	Notification Date / Time
Physician or RN (if applicable)	Notification Date / Time	Office of Recipient Rights (if applicable)	Notification Date / Time
Responsible Agency	Notification Date / Time Written Notice / Date	Law Enforcement Agency (if applicable)	Notification Date / Time
Designated Representative / Legal Guardian	Notification Date / Time Written Notice / Date	Other (please specify)	Notification Date / Time

SIGNATURE(S):

Signature of Person Completing Report	Print Name and Title	Date
Signature of Licensee / Licensee Designee / Administrator	Print Name and Title	Date

COPY DISTRIBUTION: Resident Record, Licensing Consultant, Office of Recipient Rights, Responsible agency (if required) and Designated representative