INCIDENT, ACCIDENT, ILLNESS, DEATH OR ARREST REPORT

OAKLAND COUNTY COMMUNITY MENTAL HEALTH SERVICES

344078

REPORTING FACILITY / HOME / DAY / PROGRAM NAME	NAME OF RECIPIENT	CORE PROVIDER / RESPONSIBLE AGENCY (SEE CODE ON BACK)	CASE #:
FACILITY ADDRESS	HOME NAME		DOB:
CITY STATE ZIP	HOME ADDRESS		SEX: ☐ MALE ☐ FEMALE
FACILITY PHONE # FACILITY LICENSE #			
CORPORATION NAME	HOME PHONE #		

NAMES OF STAFF INVOLVED / WITNESSES:

DATE OF INCIDENT:	TIME: [ ] AM [ ] PM	LOCATION OF INCIDENT (KITCHEN, YARD, MALL, WORKSHOP, VAN, ETC.):

EXPLAIN WHAT HAPPENED, INCLUDING ACTION TAKEN BY STAFF

PHYSICAL INJURY: ☐ YES ☐ NO

PHYSICIAN/MEDICAL FACILITY: PHONE NUMBER:	DATE AND TIME CARE GIVEN: [ ] AM [ ] PM
DIAGNOSIS & TREATMENT:	

SIGNATURE OF PERSON COMPLETING REPORT	PRINT NAME & TITLE	DATE AND TIME COMPLETED: [ ] AM [ ] PM

NAMES OF PERSONS NOTIFIED	DATE & TIME	NAMES OF PERSONS NOTIFIED	DATE & TIME
ADULT FOSTER CARE LICENSING: ☐ PHONE ☐ INCIDENT REPORT		Core Provider/Responsible Agency: ☐ PHONE ☐ INCIDENT REPORT	
OFFICE OF RECIPIENT RIGHTS: ☐ PHONE ☐ INCIDENT REPORT		PHYSICIAN OR NURSE: ☐ PHONE ☐ INCIDENT REPORT	
ADULT / CHILD PROTECTIVE SERVICES: ☐ PHONE ☐ INCIDENT REPORT		LAW ENFORCEMENT AGENCY: ☐ PHONE ☐ INCIDENT REPORT	
LEGAL GUARDIAN/Designated Representative ☐ PHONE ☐ INCIDENT REPORT		OTHER (PLEASE SPECIFY): ☐ PHONE ☐ INCIDENT REPORT	

CORRECTIVE ACTION TAKEN BY LICENSEE / DESIGNEE TO REMEDY AND/OR PREVENT RECURRENCE

SIGNATURE OF LICENSEE/DESIGNEE	PRINT NAME & TITLE	DATE AND TIME COMPLETED [ ] AM [ ] PM

CLINICAL STAFF FOLLOW-UP

COPY DISTRIBUTION: **(White)** - Recipient Rights-Oakland Co. **(Pink)** - Core Provider. **(Yellow)** - Facility Record.
If required, a copy of this form must also be submitted to AFC Licensing and to Legal Guardian / Designated representative.

CMH 2501 Rev 11/24/10

INSTRUCTIONS ON BACK OF FORM