INCIDENT, ACCIDENT, ILLNESS, DEATH OR ARREST REPORT

OAKLAND COUNTY COMMUNITY MENTAL HEALTH SERVICES

REPORTING FACILITY / HOME / DAY PROGRAM NAME FACILITY ADDRESS CITY STATE ZIP FACILITY PHONE # FACILITY LICENSE # CORPORATION NAME	NAME OF RECIPIENT HOME NAME HOME ADDRESS HOME PHONE #	CMH ( ) MORC DD ( ) MORC CRS ( ) Other ( )	Facility Number: CASE #: DOB: SEX: ( ) MALE ( ) FEMALE

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

IR CODE:

PHYSICAL INJURY: [ ] YES [ ] NO

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

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		MORC or CRS or CMH: [ ] 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: [ ] 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

I-TEAM / CLINICAL STAFF FOLLOW-UP	ORR USE ONLY

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

INSTRUCTIONS ON BACK OF FORM