ADMHS UNUSUAL OCCURRENCE INCIDENT REPORT

PRIVILEGED & CONFIDENTIAL QUALITY ASSURANCE MATERIAL

Directions: 1) Complete, 2) Submit to Program Manager, 3) PM send to QA Manager

Name of Person Completing Report _____ License _____

Person Involved in Incident _____ Client # _____

Guardian's Name (if Client if a Minor) _____

Incident Date _____ Incident Time _____ ☐AM ☐PM

Incident Location _____

Witness to Incident (Name) _____

Address _____

DESCRIPTION OF INCIDENT (Add pages if more spaces is needed for description)

Action taken by Staff:

Was psychiatrist notified (if applicable)? ☐ YES ☐ NO Comments:

Severity of Effect: ☐ None ☐ Minimal ☐ Mild ☐ Significant Death resulted? ☐ Yes ☐ No

Signature Date

Program Managers'/Nursing Supervisor's Corrective Action/Plan

Signature Date

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