MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE

CLIENT INCIDENT REPORT FORM

I. TO BE COMPLETED BY MCOSA CONTRACTED AGENCY

AGENCY TYPE: □ Outpatient □ Intensive Outpatient □ MAT/OHH □ Recovery Home

Program: License Number: Address: City: State: Zip:	ID Number: Name: Age: Sex: M ( ) F ( )

Date of Incident:	Time:	Location of Incident:

Witnesses* Staff: Y ( ) N ( ) Name or ID Number*: Contact Phone Number: *Witnesses who are clients in treatment should be asked to sign release of information to MCOSA for possible follow up contact, but are not required to do so.	Witnesses: Staff: Y ( ) N ( ) Name or ID Number*: Contact Phone Number:

CHECK TYPE OF INCIDENT-
A. □ Death of Client
B. □ Serious illness requiring admission to hospital
C. □ Alleged cause of abuse or neglect
D. □ Accident resulting in injury to client requiring emergency room visit or hospital admission
E. □ Behavioral episode (with or without police contact)
F. □ Arrest and/or conviction
G. □ Medication error

Explanation of What Happened (if agency is to include their own incident report, indicate here and attach completed report to this form):

Immediate Actions Taken (actions taken to protect, comfort and/or assure proper treatment of the client):

Actions Taken to Remedy and/or Prevent Reoccurrence of Incident:

Signature of Person Completing Form: Date:

Send to:
MCOSA, 22550 Hall Road, Clinton Township, MI 48036
or Fax to 586-469-5568

II. TO BE COMPLETED BY MCOSA

MCOSA Investigation Findings Check all that apply: ( ) Death of Client ( ) Physical Illness Requiring Admission to Hospital ( ) Serious Challenging Behaviors	( ) Accident requiring ER visits and/or admission to hospital ( ) Arrest/Conviction of Client ( ) Medication Error

Determination:

Check one: Sentinel Event ( ) Non Sentinel Event ( )

Check one:

( ) MCOSA Plan of Action/Intervention ( ) Rationale For No Further Investigation

Provide a brief description:

MCOSA Signature: Date: