INCIDENT, ACCIDENT, ILLNESS, DEATH, OR ARREST REPORT
MACOMB COUNTY COMMUNITY MENTAL HEALTH SERVICES

Facility/Home Facility Code_____	Recipient
Facility Address	Age Sex: M( ) F( )
City Zip	Case Number
Licensee/Organization	Licensee Number

PERSONS INVOLVED/WITNESSED	PERSONS INVOLVED/WITNESSED
Name	Name
Address	Address
Phone Number	Phone Number

Date of Incident:	Time:	Location:

CHECK TYPE OF INCIDENT

A. □ Suicide
B. □ Death (non suicide)
C. □ Use of physical management **(Must also complete and attach Use of Physical Management Form)**
D. □ Emergency medical treatment due to injury or physical illness **(Must also complete and attach Emergency Medical Form)**
E. □ Hospitalization (Medical) due to injury or physical illness **(Must also complete and attach Emergency Medical Form)**
F. □ Property destruction – over $100
G. □ Serious display of verbal/behavior hostility and/or police were contacted **(Must also complete and attach Police Contact Form, if applicable)**
H. □ Emergency medical treatment due to medication error **(Must also complete and attach Medication Error Form)**
I. □ Hospitalization (Medical) due to medication error **(Must also complete and attach Medication Error Form)**
J. □ Suspected adverse reaction to medication **(Must also complete and attach Medication Error Form)**
K. □ Staff administration of incorrect medication **(Must also complete and attach Medication Error Form)**
L. □ Staff administration of incorrect dosage **(Must also complete and attach Medication Error Form)**
M. □ Staff failed to administer medication **(Must also complete and attach Medication Error Form)**
N. □ Other medication error/discrepancy **(Must also complete and attach Medication Error Form)**
O. □ Arrest of consumer
P. □ Allegations of, apparent, or suspected abuse and neglect **(Must immediately notify the Office of Recipient Rights at (586) 469-6528 or immediately fax a Recipient Rights Complaint form to (586) 466-4131 for abuse and neglect and all other possible rights violations)**

Q. □ Other

EXPLAIN WHAT HAPPENED:

ACTION TAKEN BY STAFF/TREATMENT GIVEN [INCLUDING TREATING PHYSICIAN; MEDICAL FACILITY; DIAGNOSIS OR CAUSE OF DEATH]:

ACTION TAKEN TO REMEDY AND/OR PREVENT RECURRENCE OF INCIDENT, ACCIDENT, ILLNESS, DEATH, OR ARREST

PERSONS NOTIFIED (NAME) DATE/TIME	PERSONS NOTIFIED (NAME) DATE/TIME
□ Adult Foster Care Licensing:	□ Adult/Children Protective Service:
□ Physician or RN:	□ Office of Recipient Rights:
□ Case Manager/Supports Coordinator:	□ Law Enforcement:
□ Supervisor:	□ Other (Specify):

SIGNATURE OF PERSON COMPLETING REPORT	PRINT NAME AND TITLE	DATE
SIGNATURE OF LICENSEE/ADMINISTRATOR	PRINT NAME AND TITLE	DATE