DEPARTMENT OF MENTAL HEALTH
LICENSING DIVISION

INPATIENT INCIDENT REPORT

(Reports should be submitted first business day post incident, with separate report for each affected client.)

Facility Name: _____ Incident Date and Time: _____ Date of Report_____

Reporting Person: _____ Title: _____

Client Name: _____ Admission Date: _____ AGE: ____ DOB: ____

Unit: _____ Is Unit BSAS Certified? Y☐ N☐

DMH Client: Y☐ N☐ Medical Examiner Case: N/A ☐ Y☐ N☐ Check Levels at time of incident: _____

Check Levels after incident: _____

Was this reported to any other Agency and if so, please identify (DCF, DPPC, DDS, DPH, DYS, BSAS, EA): _____

Census (time of incident) _____ Planned Staffing: _____ Actual Staffing: _____

Description of Incident: _____

Psychiatric and/or Substance Use Treatment

Diagnoses: _____

Diagnoses at discharge if applicable and/or different: _____

Medication Names & Dosages: _____

Psychiatric and/or Substance Use Treatment During Hospitalization (e.g., Individual Therapy/ECT/Groups/Family work, Substance Use Treatment)

_____

Consults: _____

Did Incident involve a patient receiving substance use disorder treatment services? Y☐ N ☐

If patient was receiving detoxification or opiate maintenance services, did the patient suffer a seizure, delirium tremens, require medical attention off the unit, etc.? If yes, please fully describe: _____

Medical Condition(s)/Treatment

Diagnoses: _____

Diagnoses at discharge if applicable and/or different: _____

Medication Names & Dosages: _____

Medical Treatments: _____

Consults: _____

Review and Findings (Please include any meetings with HRO, Family, Police etc., as well as any changes to treatment plan.): _____