**CONSUMER 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 - ( PLEASE FAX TO (586) 466-4131)**

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 **– (Please fax to (586) 463-8598)**

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 |