Department of Behavioral Wellness
UNUSUAL OCCURRENCE INCIDENT REPORT
PRIVILEGED & CONFIDENTIAL QUALITY CARE MANAGEMENT MATERIAL
Directions: 1) Complete, 2) Submit to Program Manager, 3) PM send to QCM Manager

NOT TO BE A PART OF THE CLIENT RECORD

Name of Person Completing Report ___

License ☐MD/DO ☐PhD/PsyD ☐LCSW/MFT/ASW/IMF ☐RN/LVN/LPT ☐Other Phone # ___

Person Involved in Incident ___ Client # ___

Guardian's Name if Client is a Minor: ___

Incident Date ___ Incident Time ___ ☐ AM ☐ PM

Incident Location ___

Witness to Incident – Name ___

Address ___

DESCRIPTION OF INCIDENT: (Add pages if more space 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 Manager's/Nursing Supervisor's Corrective Action/Plan

___

Signature: ___ **Date:** ___

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N O T T O B E A P A R T O F T H E C L I E N T R E C O R D

Quality Care Management Review

Signature: ______________________ Date: ____________

(Please route to ONLY THOSE checked below. Return to QCM Manager when reviews are completed.)

Review By **Patients' Rights Advocate Review/Comments**

Signature: ______________________ Date: ____________

Review By **Medical Director's Review/Comments**

Signature: ______________________ Date: ____________

Review By **Assistant Director, Review/Comments**

Signature: ______________________ Date: ____________

Review By **Assistant Director, Programs Review Review/Comments**

Signature: ______________________ Date: ____________

Review By **Mental Health Director's Review/Comments**

Signature: ______________________ Date: ____________