

Person reporting incident/accident:	Status: Staff	Date of incident: Click here to enter a date.	Time of incident:	
Date reported: Click here to enter a date.	Time reported:	Administrator notified:	Prior police report: <input type="checkbox"/> Yes <input type="checkbox"/> No	Department:
Name/address where incident/accident:			Was security notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Type of Incident: <input type="checkbox"/> Dangerous Situation <input type="checkbox"/> Accident or Injury <input type="checkbox"/> Grievance <input type="checkbox"/> Mental Health (See Addendum)	Condition of area: <input type="checkbox"/> Dry <input type="checkbox"/> Wet: <input type="checkbox"/> Posted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Icy: <input type="checkbox"/> Salted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other : _____ Lighting: <input type="checkbox"/> Well lighted <input type="checkbox"/> Poorly lighted	Weather conditions: Approximate Temp.: _____ Fahrenheit <input type="checkbox"/> Clear <input type="checkbox"/> Snow <input type="checkbox"/> Cloudy <input type="checkbox"/> Tornado warning <input type="checkbox"/> Rain <input type="checkbox"/> Other: _____
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Where did incident occur: <input type="checkbox"/> In Building <input type="checkbox"/> In Parking lot <input type="checkbox"/> On Grounds <input type="checkbox"/> In Vehicle <input type="checkbox"/> Other: _____	Police called: <input type="checkbox"/> Yes <input type="checkbox"/> No Police response <input type="checkbox"/> Yes <input type="checkbox"/> No Dept.: _____ Report # _____	Fire Dept. called: <input type="checkbox"/> Yes <input type="checkbox"/> No Dept. : _____ Report # _____ Ambulance called <input type="checkbox"/> Yes <input type="checkbox"/> No Company : _____	Other people and Agencies contacted: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
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Primary person involved in incident/Accident:	Status: Select below	Date of Birth:	Telephone number:
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Home address:			
Street	City	State	Zip
First aid given: <input type="checkbox"/> Yes <input type="checkbox"/> No	Given By: _____	Taken to Hospital <input type="checkbox"/> Yes <input type="checkbox"/> No Which one: _____	Person refused medical treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No
Witnesses 1. _____ 2. _____ 3. _____	Status: Select below Select below Select below		Telephone number _____ _____

Narrative: Briefly describe incident in your own words:

Immediate follow-up action taken:

Further recommendations for action:

Reports/statements attached Photographs attached

I certify that all information in this report is true to the best of my knowledge.

Person preparing report. _____ Signature: _____

Is this a mental health related incident? If yes, please complete the Mental Health Incident Addendum below.

MENTAL HEALTH INCIDENT REPORT ADDENDUM



Suicide Risk Management Incident Report

This report will be filled out if a client is deemed to be high risk for suicide or moderate risk for suicide, but requiring urgent intervention.

Date of Reporting: _____

Risk Criteria:

- Suicidal ideation or homicidal ideation with method, intent or plan Yes___ No___
- Suicide attempt since last assessment Yes___ No___
- A verbal statement of clear intent or plan to attempt suicide Yes___ No___
- Clinical judgment that a combination of risk factors places the client at high risk for suicide or harm to others Yes___ No___

What was said during the assessment?

Potential Interventions:

- Was the client told of the need to talk to collateral informants (others who know them)? Yes___ No___
- Were collateral informants contacted? Yes___ No___
- Was the client reminded to use safety plan, crisis line, text line? Yes___ No___
- Was the client told to pursue emergency intervention (PES)? Yes___ No___
- Did the client agree to pursue emergency intervention? Yes___ No___
- Did the client follow through with pursuing emergency intervention? Yes___ No___
- Was means reduction counseling implemented? Yes___ No___
- Was supervisor contacted? Yes___ No___
- Was the Washtenaw County Crisis Team contacted? Yes___ No___
- Was 9-1-1 called? Yes___ No___
- Was a petition filled out? Yes___ No___

Additional Comments:

I certify that all information in this report is true to the best of my knowledge.

Person preparing report: _____ Signature: _____