|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Name(full):**  **Client DOB:** | | | | **Reporting Staff:**        **Position:** | |
| **Event was:**  **Witnessed by Staff**  **Reported to Staff** | | | | **Date of Incident:**  **Date Reported to Staff:** | |
| **Reporting Supervisor:** | | **Clinic/Provider:** | | | **Date of Report:** |
| **Client Present?** **Yes**  **No** | | **Staff Present:** | | | **Family Members Present:** |
| **Time of Event:** | Time: | | Outside of Appointment  During Appointment:  Start  End  Mid. | | |
| **Site of Event:** | Inside Clinic or Building  Client Home  Outside Clinic Building  Other: | | | | |
| Description Of event *(Facts only: who, what, when, where, how;*  ***no*** *conclusions or opinions)* |  | | | | |
| What led up to the event? |  | | | | |
| How did staff respond to the event? |  | | | | |
| How was the event resolved?  *(If not applicable, state “N/A”)* |  | | | | |
| **Action(s) taken**  *(select as many as appropriate)* | 911 notified  First Aid Given  Verbal Intervention  CPS notified (attach copy of report)  Other: | | | | |
| **Family/Parent**  **Communication** | Family or Caregiver present Family or Caregiver informed  *Additional Comments:* | | | | |
| **Is follow up with**  **Family needed?** | **Yes**  **No** | | | | |

|  |  |  |
| --- | --- | --- |
| **Check applicable event type (s):** | | |
| Abuse or Neglect | Client Danger to Self | Client Danger to Others |
| Communicable Disease | Infection Control/Biohazard Accident | Medical Emergency or Injury |
| Medication Error | Responsible Adult Aggression | Responsible Adult Danger to Self |
| Responsible Adult Danger to  Others | Unauthorized use and possession of  legal or illegal substances | Use of Restraint/Seclusion |
| Wandering/Elopement | Other: | |

**\*\* Please submit to your Supervisor/Manager \*\***

**Supervisor Review:**

**Date Supervisor Reviewed with Client, family, and/or staff:**

**Supervisor’s** **Summary and additional notes:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Recommended**  **Actions** | |  | | --- | |  | |  | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Reporting Staff Name (Print)** | **Signature** | **Date** | **Contact Phone Number** |
|  |  |  |  |
| **Supervisor’s Name (Print)** | **Signature** | **Date** | **Contact Phone Number** |
|  |  |  |  |

**\*\* Upon completion of this form, email to** [theBHPN@theBHPNP.org](mailto:theBHPN@theBHPNP.org)\*\*