1) Date of Report:       2) County:

3) Incident Date and Time:       4) Date and Time known to Agency:

5) Alleged Victim Name(s):

6) Alleged Perpetrator Name(s) (if applicable) and relationship to victim:

7) Identified witnesses (if applicable):

8) Location of Incident:

9) Reporting Agency Name, Address & Program Element:

10) Type of Incident: (check all appropriate categories)

[ ]  Death, Expected

[ ]  Death, Sudden and Unexpected

[ ]  Alleged Suicide Attempt

[ ]  Alleged Physical Abuse

[ ]  Alleged Physical Assault (Moderate/Major Injury)

[ ]  Alleged Sexual Abuse

[ ]  Alleged Sexual Assault

[ ]  Medical

[ ]  Sexual Contact

[ ]  Rights Violation

[ ]  Alleged Exploitation

[ ]  Alleged Neglect

[ ]  Alleged Verbal/Psychological Abuse

[ ]  Criminal Activity

[ ]  Elopement/Walkaway

[ ]  Injury (Moderate/Major)

[ ]  Overdose

[ ]  Media Interest

[ ]  Operational

[ ]  Contraband

11) Provide a detailed description of incident being reported:

***DMHAS USE ONLY***

UIRMS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Code: \_\_\_\_\_\_\_\_\_\_\_ Secondary Code: \_\_\_\_\_\_\_\_\_\_\_ Closing Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consumer(s) Involved**

*Complete all information below for each individual consumer involved in this incident (attach additional sheets if needed).*

1) First Name:       Last Name:

2) Date of Birth:       3) Gender:

4) Phone:

5) Address:

6) The role of the aforementioned consumer: [ ]  Alleged Victim [ ]  Alleged Perpetrator

7) Was this consumer on agency site or in presence of staff at the time of this incident? [ ]  Yes [ ]  No

 If Yes: Agency Name:

 Agency Site/Address:

 Agency Program Element:

8) Consumer’s Residential Service Provider’s information:

 Level of care: [ ]  A+, [ ]  A, [ ]  B, or [ ]  C

 Agency Name:

 Agency Site/Address:

 Agency Program Element:

9) Is this consumer also served by the New Jersey Division of Developmental Disabilities (DDD)? [ ]  Yes [ ]  No

 If Yes: Case Manager Name:

 Case Manager Contact Information:

10) Identify other services (within or outside your agency) that this consumer is involved in, including MH and/or SUD:

 Agency Name:       Agency Site/Address:       Agency Program Element:

 Agency Name:       Agency Site/Address:       Agency Program Element:

 Agency Name:       Agency Site/Address:       Agency Program Element:

 Agency Name:       Agency Site/Address:       Agency Program Element:

11) How long has this consumer been receiving services from your agency (include date of admission)?

12) How often is this consumer seen by your agency?

 The consumer’s scheduled number of hours       and scheduled number of days per week      .

 The consumer’s actual number of hours of attended       and actual number of days attended per week      .

13) When was this consumer last seen by your agency PRIOR to the incident?

**Consumer Name:**       **Incident Date:**

14) Has this consumer been discharged within the last 60 days from a STCF, CCIS, state, county or private psychiatric hospital or another community mental health agency?

[ ]  No [ ]  Yes, specify the hospital name and discharge date:

15) Does this consumer have any legal/criminal status?

[ ]  No [ ]  Yes, specify status:

16) Diagnoses:

 DSM Diagnoses:

 Medical Diagnoses:

17) ASAM Level of Care:

18) Medications:

 Psychiatric Medications:

 Medical Medications:

19) Notifications, including family, local law enforcement and Prosecutor’s Office:

 Name:       Title:       Date:       Time:

 Name:       Title:       Date:       Time:

 Name:       Title:       Date:       Time:

20) Immediate actions taken or other actions planned (include responsible party):

This document was prepared by:       Title:

Date:       Time:       Phone number:       E-mail address:

Contact person if different than the preparer:       Title:

 Phone number:       E-mail address:

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***If you have received this in error, please call 1-800-382-6717 immediately.***