FAMILIES FIRST

CRITICAL INCIDENT REPORT

Client's Name: _____

Guardian's Name: _____

Name of Person Reporting: _____

Type of Incident (check all that apply):

_____ Death _____ Hospitalization _____ Injury Requiring Medical Attention

_____ Criminal Act _____ Missing Person _____ Medical Treatment due to Med Errors

_____ Suspected Abuse, Neglect or Exploitation _____ Other Unusual or Significant Event

Date of Incident: _____ Time: _____.

Location: _____

Description of Incident: _____

_____

_____

Action Taken: _____

_____

Who was notified about this incident? (check all that apply)

_____ Service Coordinator _____ Agency Director _____ Agency Nurse _____ Guardian

_____ Physician _____ DS _____ APS _____ DCF

Is Follow-Up Needed? _____ Yes _____ No If yes, describe the follow-up plan: _____

_____

Signature of Staff Completing Form: _____ Date: _____

Supervisor's Signature: _____ Date: _____.

Comments: _____

_____.

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