RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
INCIDENT REPORT - CONFIDENTIAL

PROGRAM NAME RU# STAFF MAKING REPORT

CLIENT NAME DOB RCDMH CLIENT ID#

The above named client was involved in an act/action which meets/may meet (circle one) the requirements of the formation of the Adverse Incident Committee. The incident falls into one of the following categories (circle all that apply).

1. Physical injury to any client or clinic visitor requiring medical attention.
2. Suicide.
3. Significant injury caused by suicide attempt.
4. Homicide.
5. Significant injury caused by physical assault/battery by client upon another.
6. Significant injury caused by physical assaults on clients or visitors.
7. Significant injury to client while at clinic site.
8. Death of client by other than natural causes.

THE EVENTS WHICH OCCURRED ARE AS FOLLOWS:

SUBMISSION DATE: _____ TIME: _____

TO WHOM SUBMITTED_____

SUBMIT THIS FORM TO SUPERVISOR WITHIN 24 HOUR OF INCIDENT
DO NOT PLACE THIS FORM OR ANY COPY OF THIS FORM IN CHART