Riverside University Health System – Behavioral Health
REPORT OF INCIDENT FORM
DMH FORM 408-6

Involved Individuals: ____
Last Name First Name Client ID# (if applicable)

____
Address Street City

____
(Area Code) Telephone No. Age

Involved Is: Client ______________ Employee ______________ Visitor ______________

Report File By: ____
Name/Title Date Telephone No. Clinic

Date, Time & Location of Incident: ______________________________ Date of this Report: __________

Type of Incident: ______________________ Primary DX (when applicable): ______________________

Severity of Incident: ____

IS THIS A POSSIBLE LICENSE VIOLATION? Yes No
Comments:

Client on Meds? ☐ Yes ☐ No ☐ Unknown. If yes, list meds and dosages: ______________________

____

Suspected or Known Alcohol or Drug Abuse: ____

____

Primary Psychiatrist (when applicable): ____

Brief Description of Incident: ____

____

Confidential patient information. See California Welfare and Institutions Code Section 5328

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Family/Legal Guardian – Aware of Incident: ☐ Yes ☐ No

Family Attitude ______________________________

____

Client Comments: ______________________________

____

1. Witness: Name: ____________________ Telephone No: ____________________

   Account of Incident: ______________________________

____

2. Witness: Name: ____________________ Telephone No: ____________________

   Account of Incident: ______________________________

____

Supervisor's Comments: ______________________________

____

Regional/Program Manager Notified? ☐ Yes ☐ No Date & Time Notified: ____________________

DO NOT FILE THIS FORM IN CLIENT RECORD – DO NOT DUPLICATE

Original to: Professional Risk Management. Copy to: Medical Director

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