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| **DEPARTMENT OF HEALTH SERVICES DIVISION OF BEHAVIORAL HEALTH SERVICES****ADVERSE INCIDENT REPORT – SUPPLEMENTAL INFORMATION REPORT** |
| **Date of Incident:** **Date of Initial Report:** **Client Name:** **Age:** **DOB:** **EHR#:****Agency/Facility/Program:** **Assigned Worker:** **Supervisor:** **Agency Designee:** **Contact Number:**  |
| **Additional information reported or discovered since initial report:**  |
| **Additional action taken since initial report:**  |

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| **Client response to initial action taken:**  |
| **Signatures and Date:** **Agency Designee:** **Date:****County Program Coordinator/Contract Monitor:** **Date:****County Program Manager:** **Date:****County Division Manager:** **Date:****DBHS Director:** **Date:** |
| **For Internal County Use Only Additional follow up actions taken:**  |