|  |
| --- |
| **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:** |

|  |
| --- |
| **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:** |