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:

Route: One to Quality Management, One to Contract Monitor/Program Coordinator, One to Agency Adverse Incident

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:

Route: One to Quality Management, One to Contract Monitor/Program Coordinator, One to Agency Adverse Incident