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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:** Click or tap here to enter text. |
| **Additional action taken since initial report:** Click or tap here to enter text. |

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| **Client response to initial action taken:** Click or tap here to enter text. |
| **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:** |