**Initial Incident Report Form**

**New Jersey Department of Human Services**

**Division of Mental Health & Addiction Services**

Reports must be submitted no later than one (1) working day following the date the incident was known to the agency. Submit reports to: dmhs.incidentrept@dhs.state.nj.us or Northern Region Fax # 973-977-6024 or Southern Region Fax # 609-341-2316.

1. **Date of Report:**Click here to enter text.
2. **County/Region:** Click here to enter text.
3. **Incident Date and Time:** Click here to enter text.
4. **Date and Time known to Agency:** Click here to enter text.
5. **Alleged Victim Name(s):** Click here to enter text.
6. **Alleged Perpetrator Name(s) (if applicable) and relationship to victim:** Click here to enter text.
7. **Identified witnesses (if applicable):** Click here to enter text.
8. **Location of Incident:** Click here to enter text.
9. **Reporting Agency Name, Address & Program Element:** Click here to enter text.

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| [ ]  **Death, Expected** [ ]  **Alleged Exploitation**[ ]  **Death, Sudden and Unexpected** [ ]  **Alleged Neglect**[ ]  **Suicide Attempt** [ ]  **Alleged Verbal/Psychological  Abuse**[ ]  **Alleged Physical Abuse** [ ]  **Criminal Activity** [ ]  **Alleged Physical Assault** [ ]  **Elopement/Walkaway** [ ]  **Alleged Sexual Abuse** [ ]  **Injury**[ ]  **Alleged Sexual Assault** [ ]  **Media Interest**[ ]  **Medical** [ ]  **Operational** |

1. **Type of Incident: (check all appropriate categories)**
2. **Provide a brief description of incident being reported:** Click here to enter text.

**(For DMHAS Use Only)
UIRMS #:**Click here to enter text. **Primary Code:**Click here to enter text. **Secondary Code:**Click here to enter text.

**Consumer(s) Involved**

Please complete all information below for each individual consumer involved in this incident. [(Attach additional sheets if needed)](http://www.dhs.state.nj.us/co/opia/Documents/Additional%20Consumers.docx)

1. **First Name:** Click here to enter text.
**Last Name:** Click here to enter text.
2. **D.O.B:** Click here to enter text.
3. **USTF#:** Click here to enter text.
4. **Gender:** Click here to enter text.
5. **Identify the role of the aforementioned consumer below:**
[ ]  Alleged Victim [ ]  Alleged Perpetrator
6. **Consumer on agency site or in presence of staff at the time of this incident:** [ ]  **Yes** [ ]  **No
(Identify the Agency, site and program element if checked yes)**
Click here to enter text.
7. **Consumer’s Residential Service Provider’s information; identify the level of care:**[ ]  **A+,** [ ]  **A,** [ ]  **B,** [ ]  **C.**
**Agency Name:** Click here to enter text.
**Site/Address:** Click here to enter text.
**Program Element:** Click here to enter text.
8. **Is this consumer also served by the New Jersey Division of Developmental Disabilities (DDD)?** [ ] **Yes** [ ] **No**
9. **If yes to question (8) above, provide the name of the DDD case manager and contact information if applicable.** Click here to enter text.
10. **Identify other services (within or outside your agency) that this consumer is involved in:**

|  |  |  |
| --- | --- | --- |
| **Agency** | **Site** | **Program Element** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

1. **How long has this consumer been receiving services from your agency?**Click here to enter text.
2. **How often is this consumer seen by your agency? Specify hours and days per week.**
Click here to enter text.
3. **When was this consumer last seen by your agency?**
Click here to enter text.
4. **Has this consumer been discharged within the last 60 days from a STCF, CCIS, state, county or private psychiatric hospital or another community mental health agency? Specify hospital name and discharge date:**
Click here to enter text.
5. **Does this consumer have any legal/criminal status? If yes, specify:**
Click here to enter text.
6. **DSM Diagnosis(es):**
Click here to enter text.
7. **List of Medications:**
Click here to enter text.
8. **Incident witnesses:**

|  |  |
| --- | --- |
| **Name** | **Title** |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |

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| --- | --- | --- | --- |
| **Name** | **Title** | **Date** | **Time** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**19) Notifications, including family, local law enforcement and Prosecutor’s Office:
20) Describe immediate actions taken or other actions planned:**
Click here to enter text.

**Prepared by:** Click here to enter text.
**Title:** Click here to enter text.
**Date/Time:** Click here to enter text.
**Phone:** Click here to enter text.
**Email:** Click here to enter text.
**Contact person if different than the preparer:** Click here to enter text.

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| CONFIDENTIALThe Information contained in this report is confidential. This document is for internal use only and is not a public document. Only those with a need to know and authority to review this report may review the report. This report may contain confidential client information, as well as protected health information, which are protected by state and federal confidentiality laws. Unauthorized disclosure of any of the contents of this report may result in civil and/or criminal penalties.**If you have received this in error, please call 1-800-382-6717 immediately.** |

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| **Agency** | **Site** | **Program Element** |
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| **Name** | **Title** | **Date** | **Time** |
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