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:** _____ **Avatar #:** _____

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

File Adverse Incident Report Form - Revised: 11/15/2018

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 File