

**CRITICAL INCIDENT REPORT FORM (CIR)**

Send typed CIR to [DBHDDincidents@dbhdd.ga.gov](mailto:DBHDDincidents@dbhdd.ga.gov)

Incident # \_\_\_\_\_

Date of Report \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Date of Discovery of Incident: \_\_\_\_\_

Time of Incident: \_\_\_\_\_

Community Provider reporting: \_\_\_\_\_

If reporting provider is a subcontractor, who is primary contractor? \_\_\_\_\_

DBHDD Region # \_\_\_\_\_ Person Completing Report \_\_\_\_\_

Contact Person: \_\_\_\_\_ Contact Person phone #: \_\_\_\_\_

Name of site and/or specific location where incident occurred (i.e.: Unit name/number, Name of CLA/PCH, etc): \_\_\_\_\_

Check appropriate box Community Residential Program  CLA  Crisis Stabilization  Crisis Support Home  Day Program   
Host Home  In Community  Local Hospital  PCH  PRTF  Personal Residence  Respite  TIS

Other (please specify): \_\_\_\_\_

**Individual(s) Information\***

Name (first, last) \_\_\_\_\_ DOB \_\_\_\_\_ Age at Time of Incident \_\_\_\_\_ Sex Female  Male

Address \_\_\_\_\_ City \_\_\_\_\_ State GA Zip \_\_\_\_\_ County \_\_\_\_\_

Medicaid Waiver? Yes  No  CID/MHID # \_\_\_\_\_ SS# \_\_\_\_\_ Race \_\_\_\_\_

Admission Date \_\_\_\_\_ Disability: MH  DD  AD  Check box if participant directed services

List agency services in which individual is enrolled: \_\_\_\_\_

Treatment required:

None  Minor first aid  Treatment beyond first aid  Medical hospitalization

Brief description of injury: \_\_\_\_\_

Name (first, last) \_\_\_\_\_ DOB \_\_\_\_\_ Age at Time of Incident \_\_\_\_\_ Sex Female  Male

Address \_\_\_\_\_ City \_\_\_\_\_ State GA Zip \_\_\_\_\_ County \_\_\_\_\_

Medicaid Waiver? Yes  No  CID/MHID # \_\_\_\_\_ SS# \_\_\_\_\_ Race \_\_\_\_\_

Admission Date \_\_\_\_\_ Disability: MH  DD  AD  Check box if participant directed services

List agency services in which individual is enrolled: \_\_\_\_\_

Treatment required:

None  Minor first aid  Treatment beyond first aid  Medical hospitalization

Brief description of injury: \_\_\_\_\_

\*Add additional individuals on supplemental form c.1. If supplemental form is used, please check

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**Type of Incident**

Category I (check all that apply)

Check here if incident is high visibility  \*\*

<input type="checkbox"/>	Alleged Exploitation-Staff to Individual
<input type="checkbox"/>	Alleged Individual Abuse-Physical
<input type="checkbox"/>	Alleged Individual Abuse-Psychological
<input type="checkbox"/>	Alleged Individual to Individual Sexual Assault
<input type="checkbox"/>	Alleged Neglect
<input type="checkbox"/>	Alleged Sexual Abuse
<input type="checkbox"/>	Medication errors with adverse consequences
<input type="checkbox"/>	Seclusion or restraint resulting in injury requiring treatment
<input type="checkbox"/>	Suicide attempt that results in medical hospitalization

Category II (check all that apply)

Check here if incident is high visibility  \*\*

<input type="checkbox"/>	Aggressive act between individuals resulting in injury requiring treatment beyond first aid
<input type="checkbox"/>	Alleged Individual Abuse-Verbal
<input type="checkbox"/>	Criminal Conduct by Individual
<input type="checkbox"/>	Hospitalization of an Individual in a community residential program
<input type="checkbox"/>	Incident occurring in the presence of provider staff which required intervention of law enforcement services
<input type="checkbox"/>	Individual who is unexpectedly absent from a community residential program or day program
<input type="checkbox"/>	Vehicular accident with injury while individual is in an agency vehicle or is being transported by staff

Category III (check all that apply)

Check here if incident is high visibility  \*\*

<input type="checkbox"/>	Aggressive act between individuals with injury requiring minor first aid
<input type="checkbox"/>	Individual Injury requiring treatment beyond first aid (not related to possible staff misconduct)
<input type="checkbox"/>	Staff injury caused by an individual and requiring treatment
<input type="checkbox"/>	Incident that does not meet Category I or II criteria

Brief description of incident-(include who; what; where; when; how; and any precipitating factors that may have contributed to the event, including any medical conditions that have been diagnosed; also include steps taken by facility to prevent further incidents)-

\*\*Notify Incident Management & Investigations Section at 404-657-1139 for High Visibility Incidents

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**Person(s) of Interest**

Name _____	Contact # _____	Date of Birth _____
Name _____	Contact # _____	Date of Birth _____
Name _____	Contact # _____	Date of Birth _____
Name _____	Contact # _____	Date of Birth _____

**Staff Injured**

Name _____	DOB _____	Contact # _____	Description of Injury _____
Name _____	DOB _____	Contact # _____	Description of Injury _____
Name _____	DOB _____	Contact # _____	Description of Injury _____
Name _____	DOB _____	Contact # _____	Description of Injury _____

**Witnesses to Incident**

Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>

**Notifications**

Agency	Name	Date	Time	Method of Notification
Adult Protective Services				
CPS/DFCS				
Healthcare Facility Regulation				
Support Coordinator/Planning List Administrator				
Family/Legal Guardian				
Other				
Other				
Other				
Other				
Other				

**Managerial Review**

Community provider staff/title: \_\_\_\_\_

Date: \_\_\_\_\_

By checking this box, I attest that the above entry for community provider staff/title verifies my review of the incident.