CRITICAL INCIDENT REPORT FORM (CIR) supplemental

Send typed CIR supplemental to DBHDDincidents@dbhdd.ga.gov

Incident date **Incident #**

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:

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: