CONNECTPLUS Therapy

General Incident Report

Name of person completing this form:	
Date of this form:	
This form will be submitted to (must be at least one person):	☐ HR ☐ Clinical Director ☐ Clinical Supervisor ☐ Case Manager ☐ Social Worker ☐ Other: _____
Method of submitting this form:	☐ Email ☐ Handed to someone in person ☐ Other: _____
Incident	
Date/Time at which incident happened:	Date: _____ Time: _____
Names of people involved:	
Witnesses to incident:	
Description of incident:	
Injury/Threat of Harm (if applicable)	

Was a staff member injured?	□ Yes *If 'yes', please complete a Staff Incident/Accident Report Form (located on the intranet)* □ No
Was a client injured?	□ Yes *If 'yes', please complete a Restraint/Client Injury Form (located on the intranet)* □ No
Was someone other than a staff member or client injured?	□ Yes *If 'yes', please follow up immediately with your supervisor for further action* □ No
Is a client believed to be in danger?	□ Yes *If 'yes', please complete a Child Abuse Report Form (located on the intranet) and follow up immediately with your supervisor for further action* □ No
Remediation Steps	
Action(s) taken to ensure safety of all involved *(please summarize)*: _____ _____ _____ _____ _____ _____	Please check all that apply: □ Parent/Guardian notified □ 9-1-1 called □ Client seen by mental health professional following incident □ Client seen by medical professional following incident