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 Fax # 609-341-2324.

1) Date of Report: _____ 2) County: _____

3) Incident Date and Time: _____ 4) Date and Time known to Agency: _____

5) Alleged Victim Name(s): _____
_____
_____

6) Alleged Perpetrator Name(s) (if applicable) and relationship to victim: _____
_____
_____

7) Identified witnesses (if applicable): _____
_____
_____

8) Location of Incident: _____

9) Reporting Agency Name, Address & Program Element: _____
_____

10) Type of Incident: (check all appropriate categories)

- ☐ Death, Expected
- ☐ Death, Sudden and Unexpected
- ☐ Alleged Suicide Attempt
- ☐ Alleged Physical Abuse
- ☐ Alleged Physical Assault (Moderate/Major Injury)
- ☐ Alleged Sexual Abuse
- ☐ Alleged Sexual Assault
- ☐ Medical
- ☐ Sexual Contact
- ☐ Rights Violation
- ☐ Alleged Exploitation
- ☐ Alleged Neglect
- ☐ Alleged Verbal/Psychological Abuse
- ☐ Criminal Activity
- ☐ Elopement/Walkaway
- ☐ Injury (Moderate/Major)
- ☐ Overdose
- ☐ Media Interest
- ☐ Operational
- ☐ Contraband

11) Provide a detailed description of incident being reported:

_____
_____
_____
_____
_____
_____
_____
_____
_____

DMHAS USE ONLY

UIRMS #: _____ Primary Code: _____ Secondary Code: _____ Closing Entity: _____

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Consumer(s) Involved

Complete all information below for each individual consumer involved in this incident (attach additional sheets if needed).

1) First Name: _____ Last Name: _____

2) Date of Birth: _____ 3) Gender: _____

4) Phone: _____

5) Address: _____

6) The role of the aforementioned consumer: ☐ Alleged Victim ☐ Alleged Perpetrator

7) Was this consumer on agency site or in presence of staff at the time of this incident? ☐ Yes ☐ No

If Yes: Agency Name: _____

Agency Site/Address: _____

Agency Program Element: _____

8) Consumer's Residential Service Provider's information:

Level of care: ☐ A+, ☐ A, ☐ B, or ☐ C

Agency Name: _____

Agency Site/Address: _____

Agency Program Element: _____

9) Is this consumer also served by the New Jersey Division of Developmental Disabilities (DDD)? ☐ Yes ☐ No

If Yes: Case Manager Name: _____

Case Manager Contact Information: _____

10) Identify other services (within or outside your agency) that this consumer is involved in, including MH and/or SUD:

Agency	Site	Program Element

11) How long has this consumer been receiving services from your agency (include date of admission)?

_____

12) How often is this consumer seen by your agency? _____
The consumer's scheduled number of hours _____ and scheduled number of days per week _____
The consumer's actual number of hours of attended _____ and actual number of days attended per week _____

13) When was this consumer last seen by your agency PRIOR to the incident?

_____

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Consumer Name: _____ **Incident Date:** _____

14) 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?

☐ No ☐ Yes, specify the hospital name and discharge date: _____

15) Does this consumer have any legal/criminal status?

☐ No ☐ Yes, specify status: _____

16) Diagnoses:

DSM Diagnoses: _____

_____

Medical Diagnoses: _____

_____

17) ASAM Level of Care: _____

18) Medications:

Psychiatric Medications: _____

_____

Medical Medications: _____

_____

19) Notifications, including family, local law enforcement and Prosecutor's Office:

Name: _____ Title: _____ Date: _____ Time: _____

Name: _____ Title: _____ Date: _____ Time: _____

Name: _____ Title: _____ Date: _____ Time: _____

20) Immediate actions taken or other actions planned (include responsible party):

_____

_____

_____

_____

This document was prepared by: _____ Title: _____

Date: _____ Time: _____ Phone number: _____ E-mail address: _____

Contact person if different than the preparer: _____ Title: _____

Phone number: _____ E-mail address: _____