**Follow-up Incident Report Form**

**New Jersey Department of Human Services**

**Division of Mental Health & Addiction Services**

Submit no later than 45 days following the date the incident was known to the agency. Submit reports to: dmhs.incidentrept@dhs.state.nj.us or Northern Region Fax # 973-977-6024 or Southern Region Fax # 609-341-2316.

1. **UIRMS#:**Click here to enter text.
2. **Incident Date:** Click here to enter text.
3. **County:** Click here to enter text.
4. **Consumer Name:** Click here to enter text.
5. **Race/Ethnicity:** Click here to enter text.
6. **Agency Name/Address:** Click here to enter text.
7. **Primary Incident Type:** Click here to enter text. **Secondary Incident Type** (if applicable):Click here to enter text.
8. **Reason for this Report:** Choose an item. **Status:** Choose an item.
9. **Agency Findings** (Enter findings for each allegation and/or code):
**Primary Incident:** Choose an item. **Secondary Incident:** Choose an item.
10. **Describe the methods used to gather information during agency’s internal review** (i.e. consumer/staff interview, review of policies, procedures and clinical record, etc.):
Click here to enter text.
11. **Describe the incident in detail, including all new/additional information** (Note: In the event of a death, provide official cause of death and source. Attach additional pages as necessary):
Click here to enter text.
12. **Identify all consumer medications** (Include dosage, route and frequency for all psychotropic & medical medications):
Click here to enter text.
13. **Consumer Legal Status** (Does the consumer have a legal status? If yes, specify. If yes, describe any action taken by agency):
Click here to enter text.
14. **Summary of analysis/evaluation/investigation** (Include, as appropriate, information listed in Appendix 1, 2, 3 and/or 4 in this section or attach additional pages as necessary. Include alleged victim, alleged perpetrator and witness statements as appropriate):
Click here to enter text.
15. **Agency Finding(s)/Conclusion(s**)/**Action(s) to be taken** (i.e. protective, administrative, treatment, disciplinary & training actions taken to ensure safety and well-being of consumer(s)):
Click here to enter text.
16. **Other remarks/concerns/recommendations:** Click here to enter text.

Prepared by: Click here to enter text.

Title: Click here to enter text.

Date/Time: Click here to enter text.

Phone: Click here to enter text.

Email: Click here to enter text.

Contact person if different than the preparer: Click here to enter text.

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| **CONFIDENTIAL**The information contained in this report is confidential. This document is for internal use only and is not a public document. Only those with a need to know and authority to review this report may review the report. This report may contain confidential client information, as well as protected health information, which are protected by state and federal confidentiality laws. Unauthorized disclosure of any of the contents of this report may result in civil and/or criminal penalties.**If you have received this in error, please call 1-800-382-6717 immediately**. |