PHILADELPHIA OFFICE OF BEHAVIORAL HEALTH
SIGNIFICANT INCIDENT REPORT

Fax to Office of Behavioral Health at 215-413-7132 within 24 hours

1.Type of Service: Adult - Mental Health ☐ Adult - Substance Abuse ☐ Children's ☐
2.Location of Incident: OBH Residential ☐ Outpt.☐ Inpatient ☐ PHP ☐ Other day program ☐
Other ☐ *(describe):* _____

3.Consumer Name	4.Date of Birth SS#
5.Consumer Address	6.Date of Incident Time am pm
7.Reporting Agency & Provider #	8. Name, Title, Address, Phone # of person filing report
9.Agency/program where incident occurred (if other than above)	10.Location/address where incident occurred

11. Other witnesses:

12.Indicate type of incident (*Please check*) *MH only

- ☐ Death
- ☐ Homicide committed by consumer/client within 3 mo. of service
- ☐ Suicide attempt requiring medical intervention
- ☐ Violent act by or to a cons./client requiring emergency med. treat.*
- ☐ Alleged or suspected abuse (physical, sexual, financial) of or by a consumer/client*
- ☐ Adverse reaction to medication administered by a provider that requires medical attention*
- ☐ Neglect resulting in serious injury or hospital treatment*
- ☐ Arrest for criminal activity
- ☐ Fire or serious property damage at a BHS service site
- ☐ Infectious disease outbreak at a BHS provider site
- ☐ Missing person: child who has not returned home within 8 hours; at-risk adult who has not returned home within 24 hours
- ☐ Admin./ involuntary discharge or left AMA or AFA from inpatient, residential rehab.(D&A), children's resid., detox or meth. maint.

13.Summarize the incident. Include precipitating factors, current status, and a description of any injuries, medical condition, if applicable:

14.Describe any corrective actions taken to prevent reoccurrence:

Pending investigation? ☐ Yes ☐ No All pending investigations should be completed & reported within 30 days of event

15. Which of the following persons were notified by telephone?

	Person & Phone #		Person & Phone #
☐ Psychiatrist		☐ Police	
☐ Family/Significant Other		☐ Fire Dept.	
Case Mgr. ☐ ICM ☐ RC ☐D&A		☐ DHS Childline	
☐ Community Treatment Team		☐ BHSI	
☐ Mental Health Delegates		Other agency _____	

16.Signature of person filing report _____ Date _____