WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM
CRITICAL INCIDENT REPORT FOR RESIDENTIAL SERVICES
Peer Review

Name of Home:		**Report Date:**
Recipient Name:		**Recipient ID #:**
Incident Date :	**Incident Time:** ☐ AM☐ PM	**Incident Location:**
Other Recipients Involved/Present: (initials only)		
Other Employees Involved/Present:		

Notified Guardian? ☐Yes ☐No ☐N/A	**If Yes, Date:**	**Time:** ☐ AM ☐ PM
If no, why not?		

Describe the Incident: *(Be factual and descriptive. Give details on injuries or medication dosages. Attach additional sheets if needed.)*
Reported by:

Was medical treatment sought? ☐Yes ☐No ☐N/A	**If yes, where?**
Describe Treatment Provided if Injured: *(To be filled out by Doctor or Nurse, if at hospital)*	
Doctor or Nurse Signature:	***Date:***

Action Taken and/ or Comments: (*May include treatment given, persons or agencies notified, or actions to prevent recurrence.)*

Home Supervisor:	***Date:***
CSM:	***Date:***
Customer Service:	***Date:***
Safety Officer:	***Date:***
RMHA Rep:	***Date:***

Distribute within 24 hours, as follows: ☐ ***Copy for the home*** ☐ ***Copy for WMCMHS***