## CRITICAL INCIDENT REPORT

|  |  |
| --- | --- |
| Name: |  |

|  |  |
| --- | --- |
| Address: |  |
|  |
|  |

|  |  |
| --- | --- |
| Phone Number: |  |

|  |  |
| --- | --- |
| Location of Incident: |  |

|  |  |
| --- | --- |
| Date and Time: |  |

**INCIDENT:**

**(select as many as required)**

Death Physical Self Abuse

Accident – Physical Injury Suicidal Risk

Medical Emergency Hospitalization

Medical Reaction Public Complaint

Physical Aggression – To Home Visitor Property Damage

Theft Other

Possession – Drugs

Possession – Dangerous Object

**BRIEF DESCRIPTION AND THE ACTION TAKEN:**