## 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:**