Detroit Wayne Integrated Health Network

INCIDENT / ACCIDENT / ILLNESS / DEATH / ARREST / ETC.

Name of Facility/Home	License Number	Name of Resident/Recipient
Facility Address		MH-WIN Member number
Facility Phone		Age / Date of Birth
Licensee Name		Sex (circle) Male Female

OTHER PERSON(S) INVOLVED / WITNESSES:

Name	☐ Resident ☐ Employee ☐ Visitor	Name	☐ Resident ☐ Employee ☐ Visitor
Name	☐ Resident ☐ Employee ☐ Visitor	Name	☐ Resident ☐ Employee ☐ Visitor

FACTS OF THE INCIDENT (*ATTACH ADDITIONAL PAGES AS NEEDED*):

Date of Incident	Time: : ☐ AM ☐ PM	Name of Employee Assigned to Resident (if Applicable)	Location of Incident (Kitchen, Yard, etc.)

Explain What Happened / Describe Injury (if any) (Attach separate sheet if necessary):

Action taken by Staff / Treatment Given (Attach separate sheet if necessary):

Corrective Measures Taken to Remedy and/or Prevent Recurrence (Attach separate sheet if necessary):

Name of Treating Physician / Health Care / Medical Facility / Hospital	Phone Number	Date Care Given	Time: : ☐ AM ☐ PM

Physician's Diagnosis of Injury, Illness or Cause of Death, if known

PERSON(S) NOTIFIED:

AFC Licensing	Notification Date / Time Written Notice / Date	Adult Protective Services (if applicable)	Notification Date / Time
Physician or RN (if applicable)	Notification Date / Time	Office of Recipient Rights (if applicable)	Notification Date / Time
Responsible Agency	Notification Date / Time Written Notice / Date	Law Enforcement Agency (if applicable)	Notification Date / Time
Designated Representative / Legal Guardian	Notification Date / Time Written Notice / Date	Other (please specify)	Notification Date / Time

SIGNATURE(S):

Signature of Person Completing Report	Print Name and Title	Date
Signature of Licensee / Licensee Designee / Administrator	Print Name and Title	Date

COPY DISTRIBUTION: Resident Record, Licensing Consultant, Office of Recipient Rights, Responsible agency (if required) and Designated representative