Community Health and Counseling Services
MENTAL HEALTH SERVICES

OCCURRENCE REPORT

Caring and serving since 1883®

This form is used to report ***all occurrences. SUBMIT COMPLETED FORM TO SUPERVISOR (CASE MANAGER FOR FOSTER PARENTS) WITHIN 24 HOURS OF OCCURRENCE. After Supervisory review this narrative page will be filed in the client record in the Reports Section.***

Client Name: _____ **DOB** ___/___/___ **Case Number**: _____

Date of Occurrence: ____/____/____ **Time it Began**: _____ **AM/PM Duration**: _____

Regional Office or Residential Facility _____ **Unit #**_____

Exact Location of Occurrence: _____

Indicate the exact location the occurrence took place (e.g., agency parking lot, in client's kitchen, in hallway of group home, etc.).

Describe the factual details of what occurred. (Include **full names** of all employees/contractees involved. Please identify others involved by initials only.) *Describe the client's reaction. Describe actions taken by agency employee(s) / contractee(s) and others during the occurrence. Include client's response to any intervention.*

For Physical Interventions: include the non-physical intervention techniques used prior to the use of physical interventions/isolation. Please describe specific behaviors of client that warranted the use of the physical intervention/isolation(s) by staff / Foster Parent. Supervisory and/or clinical personnel will be notified about each use of physical restraint as soon as possible. If isolation was used, document if this included continuous eyes-on supervision or document each visual check on the client.

Attach additional narrative pages as needed. Sign at the end of the completed narrative.

_____ _____ _____ ____/____/____

Signature of individual completing this report *Staff #* *Title* *Date*