

CONFIDENTIAL

Client/Participant Name:

2. Describe the Serious Incident:
(Include people involved and precipitating factors)

3. Other Behavioral Health Services Client/Participant is currently receiving:
(Outpatient, case management, medication management, day treatment/rehabilitation, residential, etc.)

4. Current prescribed medication:
Name of prescribing physician:

5. Physical or medical concerns:

Report Completed By:

Title:

Print Name:

Date/Time:

Program Manager Signature:

Date/Time:

Date Faxed to County Quality Improvement:

Phone #: ()

FAX #: (619) 563-2795
County of San Diego Behavioral Health Services Administration
Quality Improvement

Telephone #: (619) 563-2781