LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

INCIDENT REPORT — PATIENT/NON-PATIENT

ASE TYPE OR PRINT CLEARLY

Patient Name:	Date of Birth	Sex	Patient File #	Date of Incident	Time	Date of Report

Facility:	Region	Location/Address: *(Be Specific)*	Admitting Diagnosis

Description of Incident: _____

Was Patient Sedated? ☐ No *(Check)* ☐ Yes	Identify Prescribed Medication(s)

Patient Attitude	Family Notified	Date	Time	Family Attitude	Equipment involved ☐ No ☐ Yes (Describe below)

Name, Address, Relationship & Phone # of Family contact or Witness to Incident.

Name of Person Making Report	Title	Telephone #	*Signature*

DO NOT DUPLICATE ***DO NOT PLACE IN CHART***

E: This report must include or be accompanied by a complete narrative explanation of related facts, observations, conversations and opinion(s) which may have a bearing on the County's defense preparation. If space allowed is not adequate please continue on separate sheet(s) to allow for detailed discription of patient history, treatment, summary of events, and perceived mood or attitude of injured or complaining person(s).

CONFIDENTIAL REPORT

M.H.-196/76I302

Call the Mental Health Department Risk Manager to determine Patient File Restrictions.

SEND TO RISK MANAGEMENT FIRM