**State Care Coordination/Maryland RecoveryNet Critical Incident Report Form**

**Date State Care Coordinator notified of Critical Incident:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Critical Incident:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Specify (SCC or MDRN)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Name/Title of Individual Completing Form**:  **Contact’s Information**  **Address:**  **City:**  **State:**  **Zip:** | **Location Where Incident Occurred:** |
| --- | --- |
| **Nature of Incident:**  **[ ] Death (from any cause after entry into SCC services) Cause of death:**  **[ ] Suicide Attempt**  **[ ] Injury to self**  **[ ] Injury to or assault on others**  **[ ] Sexual/physical abuse or neglect, or allegation thereof**  **[ ] Overdose Non-Fatal**  **[ ] Overdose (death)**  **[ ] Other (please specify:** | **Individual involved in incident:**  **Name:**  **SS#:**  **Date of Birth:**  **[ ]** **Male**  **[ ]** **Female**  **List any other involved party(s):** |

**Description of incident if known:**

**Follow-up actions taken:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**State Care Coordinator’s Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State Care Coordinators Supervisors Signature Date**

***Please send form to CIR.SCCMDRN@maryland.gov***