**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***