CRITICAL INCIDENT REPORT FORM (CIR) supplemental

Send typed CIR supplemental to MHDDAD-Incidents@dhr.state.ga.us

Incident date **Incident #**

Consumer(s) Information

Name (first, last) **DOB** **Age at Time of Incident** **Sex** **Female** ☐ **Male** ☐

Address **City** **State** **GA** **Zip** **County**

Medicaid Waiver? Yes ☐ No ☐ **CID #** **SS#** **Race**

Admission Date **Disability:** MH ☐ DD ☐ AD ☐ **Check box if consumer directed services** ☐

List agency services in which consumer is enrolled:

Treatment required:
None ☐ Minor first aid ☐ Treatment beyond first aide ☐ Medical hospitalization ☐

Brief description of injury:

Name (first, last) **DOB** **Age at Time of Incident** **Sex** **Female** ☐ **Male** ☐

Address **City** **State** **GA** **Zip** **County**

Medicaid Waiver? Yes ☐ No ☐ **CID #** **SS#:** **Race**

Admission Date **Disability:** MH ☐ DD ☐ AD ☐ **Check box if consumer directed services** ☐

List agency services in which consumer is enrolled:

Treatment required:
None ☐ Minor first aid ☐ Treatment beyond first aide ☐ Medical hospitalization ☐

Brief description of injury:

Name (first, last) **DOB** **Age at Time of Incident** **Sex** **Female** ☐ **Male** ☐

Address **City** **State** **GA** **Zip** **County**

Medicaid Waiver? Yes ☐ No ☐ **CID #** **SS#:** **Race**

Admission Date **Disability:** MH ☐ DD ☐ AD ☐ **Check box if consumer directed services** ☐

List agency services in which consumer is enrolled:

Treatment required:
None ☐ Minor first aid ☐ Treatment beyond first aide ☐ Medical hospitalization ☐

Brief description of injury:
