

**GEORGIA DEPARTMENT OF CORRECTIONS**

Name: \_\_\_\_\_

**Offender Critical Incident Notification Form**

ID #: \_\_\_\_\_

Facility: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Race: \_\_\_\_\_ Sex: \_\_\_\_\_

\*\*\*\*\*

This Offender Death Notification form must be completed by the facility MH/MR staff and **FAXED** to Office of Health Services (478-992-5865) within 48 hours following the offender's critical incident.

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**Information Concerning the Critical Incident:**

Date of Critical Incident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Location: \_\_\_\_\_

**Type of Critical Incident:** ☐ Attempted Homicide ☐ Serious Self-Injury type (more than one type can be checked):  
☐ Exsanguination (bleeding out) ☐ Cutting ☐ Hanging Attempt ☐ Near Death Overdose (Suspected) ☐ Accidental  
☐ Other (state type: \_\_\_\_\_)

Place of Critical Incident: ☐ GP ☐ Isolation/Segregation ☐ SLU ☐ Infirmary ☐ CSU/ACU/Safe Cell ☐ Other

MH/MR Level of Care: \_\_\_\_\_ MH/MR Diagnosis: \_\_\_\_\_

Medical Diagnosis/conditions: \_\_\_\_\_

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

Psychotropic Medications: \_\_\_\_\_  
\_\_\_\_\_

Medication Adherence: \_\_\_\_\_

Last three (3) MH/MR Counselor Contacts: \_\_\_\_\_

Last three (3) Psychiatric Contacts: \_\_\_\_\_

**Institutional MH Critical Peer Review panel has been scheduled to meet on \_\_\_\_/\_\_\_\_/\_\_\_\_**

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Completed on \_\_\_\_/\_\_\_\_/\_\_\_\_ Faxed on \_\_\_\_/\_\_\_\_/\_\_\_\_