GEORGIA DEPARTMENT OF CORRECTIONS

Offender Critical Incident Notification Form

Facility: ______________________________________

Date:_______________Time: ____________________

Name:____

ID#:____

DOB:____

Race:_________________Sex:____________________

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This Offender Critical Incident Notification form must be completed by the facility MH 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 Level of Care: ___________ MH Diagnosis: ____

Medical Diagnosis/conditions: ____

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____

Psychotropic Medication(s): ____

____

Medication Adherence: ____

Last three (3) MH Counselor Contacts: ____

Last three (3) Psychiatric Contacts: ____

Institutional MH Critical Peer Review panel has been scheduled to meet on_______/_______/_____

Additional Comments:

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____

Signature_________________________________ _ Completed on ______/_____/______ Faxed on _____/_____/_____

M03-01-02 (rev. 3/16) DO NOT WRITE ON BACK

Retention Schedule: Upon completion, once faxed to OHS the form shall be maintained in the mental health area for 10 years.