

PRELIMINARY REPORT OF EVENT

Program: Substance abuse Name of Facility: Growing Together, Inc.

Community _____ NRS Facility _____ xx Private Facility _____

Event (Check One): _____ Date/Time of Event: 2/16/95 2:00 P.M.

- | | |
|---|---|
| <u>Required Reporting</u>
<input type="checkbox"/> Client Abuse/Neglect
(FPSS # _____)
<input type="checkbox"/> Client Death
<input type="checkbox"/> Residential Factors
<input type="checkbox"/> Elopement
<input type="checkbox"/> Escape
<input type="checkbox"/> Altercations
<input type="checkbox"/> Suicide Attempt | <u>District Information Reporting</u>
<input type="checkbox"/> Abduction
<input type="checkbox"/> Accident/Injury
<input type="checkbox"/> Disaster (Fire, Riot, Etc)
<input type="checkbox"/> Facility/Property Damage/Theft
<input checked="" type="checkbox"/> Hospitalization
<input type="checkbox"/> Law Violation
<input type="checkbox"/> Misconduct
<input type="checkbox"/> Other _____ |
|---|---|

Participants/Witnesses

Name	Age	Race	Sex	* Client (C) Participant (P)	
				Employee (E)	Witness (W)
████████████████████	18	C	M	C	P
████████████████████	49	C	F	E	W
_____	_____	_____	_____	_____	_____

Circumstances:

Brief Description - (Attach Additional Page If Necessary.)
 Where, what, who, Extent, Contributing Factors, Status, Criminal Charge, Immediate Action Taken, Media Attention, Etc.
 Client was self mutilating and an assessment was done by Tom Schvehla, M.D. and client was admitted into Bethesda Memorial Hospital for E.C.T. therapy.

Individuals Notified

Date/Time		Date/Time	
_____	District Administrator	2/16 3:30P	Parent/Guardian
2/17/95	Client Relations	_____	HRAC/LTCOC
_____	Abuse Registry	_____	State Attorney
_____	District Program Office	_____	OLC
_____	Law Enforcement	_____	Other

 Reporting Employee Barbara Griffith Title Ex. Director
 Location Growing Together Tel. 585-0892 Date 2/17/95
 Supervisor _____ Title _____
 Review by Program Manager/Health Director Date _____

**Form to be submitted to District Program Administrator/Designee