NASSAU COUNTY OFFICE OF MENTAL HEALTH
ASSISTED OUTPATIENT TREATMENT
SIGNIFICANT EVENT REPORT

CLIENT	**COUNTY: Nassau**
DOB	**GENDER:** ☐ **M** ☐ **F**
CARE MANAGER: Click or tap here to enter text.	**PHONE #** Click or tap here to enter text.
INCIDENT DATE: Click or tap to enter a date.	**REPORT DATE:** Click or tap to enter a date.

Check *all* elements which describe what has occurred
*** Designates must be reported within 24 hours**

Criminal – Arrest, Incarceration, Accusation:

☐	Subway/Mass Transit incident of any kind*
☐	Accused of or arrested for committing a SERIOUS crime. Examples include, but not limited to*
	• Hate crime or Terrorist Threat/Act*
	• Arson (this refers to intentional fire-setting and not careless smoking) *
	• Hijacking*
	• Impersonating an officer*
	• Kidnapping*
	• Sex Offense*
	• Stalking*
	• Weapons possession*
	• Homicide*
	• Animal Cruelty*

Danger to Self or Others:

☐	Order of protection against AOT client*
☐	Commits an act of violence toward another person (not a crime, or charges not pressed) *
☐	Domestic violence*
☐	Inappropriate behavior toward children*
☐	Serious threat of harm to others*
☐	Fire or fire risk (unintentional)*
☐	Serious threat of harm to self*
☐	Serious threat of suicide with plan/intent*
☐	Commits an act of self harm*
☐	Attempts Suicide*
☐	Violates Probation/Parole*
☐	Is Incarcerated*
☐	Expresses a plan for suicide*
☐	Is the Victim of a Crime

Psychiatric Inpatient Hospital or Emergency Services Utilized:

☐	Hospitalized due to command Hallucinations of a Violent Nature*
☐	Is the subject of a removal order, 9.60/9.45*
☐	Receives psychiatric emergency room or psychiatric inpatient hospital services*

Substance Abuse:

☐	Substance Abuse associated with threatening behavior or danger to self/others*
☐	Substance abuse associated with acute relapse of symptoms

Non-Compliance with Mandated Treatment:

☐	Refuses to take court-ordered medications
☐	Refuses or is seriously non-compliant with other court mandates services

Deceased:

☐	Death, regardless of cause*

Missing:

☐	Missing (cannot be located and has had no credibly reported contact within 24 hours of the time the care coordinator or ACT team received notice that the patient was absent) *

Housing Unsecured:

☐	Loses housing and becomes unhoused*

Risk of Non-Delivery of Mandated Services

☐	At risk of being discharged from a court ordered service without a viable alternative*
☐	Has left or plans to leave county/state/country

Description:

Provide a Narrative description of the incident including the date the Care Coordinator/ACT Team became aware of the event. For events describing non-compliance, include reasons stated by the client.

Check all who have been contacted regarding this event:

☐	Outpatient Provider	☐	Physician	☐	Residence	☐	Other (specify)

☐	County AOT Coordinator	☐	Police/Jail	☐	Probation/Parole		
☐	Substance Abuse Program	☐	Family	☐	Hospital		

Recommended Actions:

1. Is any emergency evaluation or hospitalization recommended?

☐ **No, client already in ER or hospital** ☐ **No, client can be managed in community**
☐ **Yes: specify plans, e.g. call for 72 hour pick up evaluation, etc.**

2. Is any change in the treatment plan recommended (e.g., type of frequency of services, providers)? Is any change in the treatment plan requested by the client? Please elaborate:

3. Is there any need for a case conference? ☐ **Yes** ☐ **No.**