



CBHNP

Critical Incident Report

Date of Report: _____

Name of Member (Last, First, MI):	Provider Name:		
Gateway Health Plan® Member ID Number:	Gateway Health Plan® MA Provider ID Number:		
Member Address, including County	Provider Address Level of Care		
Member Telephone	Provider Contact Name and Telephone Number		
Date of Birth	Date of Admission and Discharge (if Applicable)		
Location of Incident and Provider Staff Involved	Date of Incident Time of Incident		
<p>Check type of Incident (Please refer to Provider Info on Critical Incident Reporting for definitions)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Medication error <input type="checkbox"/> Any event requiring the services of the fire department, or law enforcement agency <input type="checkbox"/> An injury or illness (non-psychiatric) of a Member requiring medical treatment more intensive than first aid <input type="checkbox"/> A Member who is out of contact with staff for more than 24 hours without prior arrangement, or a Member who is in immediate jeopardy because he/she is missing for any period of time </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter in place or relocation of residents <input type="checkbox"/> Seclusion <input type="checkbox"/> Restraint Was the Member injured as part of a restraint? Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Death of a Member <input type="checkbox"/> Abuse or alleged abuse involving a Member <input type="checkbox"/> Other incident identified by the Provider as Critical, Adverse or Unusual. Please specify: </td> </tr> </table>		<input type="checkbox"/> Suicide attempt <input type="checkbox"/> Medication error <input type="checkbox"/> Any event requiring the services of the fire department, or law enforcement agency <input type="checkbox"/> An injury or illness (non-psychiatric) of a Member requiring medical treatment more intensive than first aid <input type="checkbox"/> A Member who is out of contact with staff for more than 24 hours without prior arrangement, or a Member who is in immediate jeopardy because he/she is missing for any period of time	<input type="checkbox"/> Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter in place or relocation of residents <input type="checkbox"/> Seclusion <input type="checkbox"/> Restraint Was the Member injured as part of a restraint? Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Death of a Member <input type="checkbox"/> Abuse or alleged abuse involving a Member <input type="checkbox"/> Other incident identified by the Provider as Critical, Adverse or Unusual. Please specify:
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Describe what happened and any circumstances that may have precipitated the incident. <u>Use additional sheets if necessary.</u>			
Outcome/Resolution of event: <u>Use additional sheets if necessary.</u>			
Treating Physician's Name and Statement (if applicable)			
What action has been taken to prevent reoccurrence? <u>Use additional sheets if necessary.</u>			
Mandatory Notification Completed: <input type="checkbox"/> Child Line <input type="checkbox"/> Older Adults Protective Services <input type="checkbox"/> Other: <input type="checkbox"/> County _____	Name of County Representative Notified & Office: <hr/> Name of Relative or Guardian Notified & Relationship:		
Submitted by: Name Title	Signature and Date		



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For CBHNP Internal Use Only

CBHNP Action and Documentation:

_____ Date Critical Incident Report Received by CBHNP.

_____ Date of Review by Director of QI, or designee.

Signature of Reviewer

Action Taken:

- No further action required at this time. Continue established monitoring and reporting.
- Request additional clarification from Provider:

- Imminent patient safety issue identified and referred to Medical Director/Assistant Medical Director/Physician Reviewer and Clinical Director for review. (County and CABHC to be notified).
- Alleged or actual Fraud or Abuse issue identified and referred to Corporate Compliance Officer for review.
- Referred to Quality of Care Council for additional review.

NOTES: (Indicate Level of Care if applicable for incident)