

CBHNP Critical Incident Report

Date of Report

Name of Member (Last, First, MI) Number	MA Identifier	Provider Name	Promise Number/Type		
Member's County of Residence		Provider Address			
Date of Birth		Provider Contact Name and Telephone Number			
Level of Care		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%; 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%; 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:		Name of County Representative Notified & Office:			
<input type="checkbox"/> Child Line <input type="checkbox"/> Older Adults Protective Services <input type="checkbox"/> Other: <input type="checkbox"/> County _____		Name of Relative or Guardian Notified & Relationship:			
Submitted by:	Name	Title	Signature and Date		