

Critical Incident Report

Date of Report: _____

Name of Member (Last, First, MI):	Provider Name:	Promise Number/Type:
MA Identifier Number:	Level of Care:	
Member Home Address, including County:	Provider Address:	
Member Telephone:	Provider Contact Name and Telephone Number:	
Date of Birth:	Date of Incident:	Time of Incident:
Location of Incident:	Date Provider notified of incident:	
Provider Staff involved:	Is this an addendum to a previously submitted report? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of initial report: _____	

Check type of Incident (Please refer to PerformCare Policy QI_-CIR-001 Critical Incident Reporting)

<input type="checkbox"/> The actual occurrence of a potentially lethal suicide attempt that requires medical treatment greater than first aid and/or the individual suffers or could have suffered significant injury <input type="checkbox"/> Medication error resulting in the need for urgent or emergent medical intervention <input type="checkbox"/> Provider Preventable Conditions (PPC) <input type="checkbox"/> Any Member event requiring fire department or law enforcement agency engagement while Member is on Provider site or Provider is present <input type="checkbox"/> Overdose requiring treatment greater than first aid <input type="checkbox"/> Serious injury to Member requiring treatment greater than first aid while Member is on Provider site or Provider is present <input type="checkbox"/> Life threatening illness requiring hospitalization of a Member while on Provider site or Provider is present. <input type="checkbox"/> A Member receiving 24-hour care services who is out of contact with staff <input type="checkbox"/> Member injury requiring treatment greater than first aid due to restraint or seclusion or improper use of restraint or seclusion	<input type="checkbox"/> Unanticipated death occurring in a behavioral health treatment setting, completed suicide, overdose, apparent serious physical accident and/or suspicious death <input type="checkbox"/> Any condition that results in a temporary closure of a 24-hour facility <input type="checkbox"/> Allegations of sexual or physical abuse/neglect/exploitation by a Provider (<i>*Complete Mandatory Notification Section below</i>) <input type="checkbox"/> Allegations of physical or sexual abuse between peers while on provider site or while provider is present (<i>*Complete Mandatory Notification Section below</i>) <input type="checkbox"/> Consensual sexual contact between peers both under the age of 18 while on provider site or while provider present <input type="checkbox"/> Severe physical aggression resulting in damage to property or injury to staff or peers that requires treatment greater than first aid that occurs on Provider site or while Provider is present <input type="checkbox"/> Other occurrence representing actual or potentially serious harm to a Member: _____
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Describe what happened and any circumstances that may have precipitated the incident. Use additional sheets if necessary.

Outcome/Resolution of event: (Please include any medical or crisis assessments that may have occurred)

What action has been taken to prevent reoccurrence? (Please include if safety/crisis plan implemented or updated)

*Mandatory Notification Completed: <input type="checkbox"/> Child Line <input type="checkbox"/> Adult Protective Services <input type="checkbox"/> Older Adult/ Office of Aging Date Completed: _____ Reference No: _____ OR Name of person reported to: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> County if applicable: _____	Submitted by: Name Title Contact Number Signature and Date
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