

**Department of Health and Human Services/Office of Child & Family Services
Critical Incident Reporting Form**

The reporting, evaluation, and analysis of critical incidents is a DHHS/OCFS quality improvement activity as required by statute (Title 34B MRSA Section 1207). Informing clients of this activity is the responsibility of the licensed contracting provider.

<p>The following types of incidents must be reported by phone to the DHHS/OCFS Team Leader or designee immediately (within 4 hours) after incident becomes known to staff and followed by a faxed incident report to fax # 287-6156</p> <p><u>Level I incidents</u></p> <ul style="list-style-type: none"> A. Suicides B. Homicides/other unexplained deaths C. Major physical plant disasters D. Other events that significantly jeopardize client and/or public safety [e.g., serious crimes (assault or hostage taking), serious injury to consumer or staff requiring emergency medical intervention, arson, lost or missing client with adverse results, etc.; or with children events which present extreme risk of harm] D1. Serious suicide attempt 	<p>The following incidents must be reported by phone to the DHHS/OCFS Resource Coordinator Nadine Martin within 24 hours after an incident becomes known to staff and followed by a faxed incident report to fax # 287-6156:</p> <p><u>Level II incidents</u></p> <ul style="list-style-type: none"> A. Major medication errors or other adverse clinical events resulting in the need for immediate/emergency medical attention B. Alleged physical and/or sexual abuse of a client by a staff member or by another client; or with children a report of current physical or sexual abuse filed with DHHS child protective services.
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INCIDENT DESCRIPTION (please print or type)

Client Name: _____

Parents/Guardian Name (if applicable): _____

Client Identification Number: _____ (agency/provider client i.d. number
for client involved in incident)

Descriptive Data: (1) Male (2) Female Age: _____ Date of Birth: _____ -- --

Current Residence: County: _____ ; Town/City: _____

Class Member Status (Check one): (1) AMHI Class (3) Community MR Class
 (2) Member of both (4) Not a Class Member

Level of Incident I II **Type of Incident** (A, B, C, D, D1): _____

Date of Incident: _____ **Time of Incident:** _____

Location of Incident: _____

Date/Time Received by DHHS/OCFS: _____

Incident Summary Description (brief): (attach additional sheet if necessary)

Staff Response: (Use categories below; include specific actions taken by agency/facility & person(s) involved in response)

1. **Client safety secured:**

2. **Medical attention required:**

3. **Administrative response (both for this child and for agency)**

4. **Treatment Response (what was learned and how will future episodes be prevented?)**

Person(s) Notified: (List all individuals who were notified of the event):

- Guardian Client's family Psychiatrist

Name:

- Police DHHS Protective Services Agency administrator

Name:

- Medical provider/doctor Case manager Therapist

Name:

- Other (describe):

Staff Member Submitting Report: (PRINT) **Telephone:** _____

Agency Name and Unit:

Program Area Affiliation (Check one)

- (1) MR/DD (Adult)
 (2) Mental Health (Adult)
 (3) Children
 (4) Substance Abuse Services

Program Type (Check one)

- (1) Residential (2) Hospital Inpatient
 (3) Case management (4) Outpatient
 (5) Crisis
 (6) Other _____

Signature of Person Completing Report: **Supervisor Signature:** _____