Rev. 10/16

Critical Incident Form

Clear Form

(ABI, ABI-LT, HCB, MPW, SCL, SGF)

Confidentiality Notice: This document contains confidential and privileged information.
Any unauthorized review, use, disclosure or distribution if prohibited.

Funding Source:	☐ ABI	☐ ABI-LTC	☐ HCB	☐ MPW	☐ SCL	☐ SGF
Participant Directed Services?:	☐					

Individual's Last Name: _____

Individual's First Name: _____

Social Security Number: _____

Date of Birth: _____

Medicaid Number: _____

Reporting Agency: _____

Reporter's Last Name: _____

Reporter's First Name: _____

Reporter's Phone: _____

Reporter's Title: _____

Detail and Notification of Critical Incident

*IMMEDIATELY NOTIFY DCBS, Case Manager, guardian and regulating agency if Suspected Abuse, Neglect or Exploitation are selected.
Otherwise, notify Case Manager, guardian and regulating agency within (8) hours of Critical Incident.

- ☐ *Suspected Abuse
- ☐ *Suspected Neglect
- ☐ *Suspected Exploitation
- ☐ Homicidal Ideation
- ☐ Other (Describe):

_____

- ☐ Missing Person
- ☐ Serious Med Error
- ☐ Death
- ☐ Suicidal Ideation
- ☐ Loss of Limb

Name of Location of Incident:

_____

Address and County of Critical Incident:

_____

_____

Critical Incident: Date: _____ Time: _____

Discovery: Date: _____ Time: _____

Location Phone Number (*Include Area Code*):

_____

Regulating Agency:

Notification: _____

Date: _____ Time: _____

Case Manager Notification:

Date: _____ Time: _____

CM Agency Name: _____

CM Phone #: _____

CM Name: _____

Guardian Notification:

Date: _____ Time: _____

Name: _____

DCBS Notification:

Hotline ID #: _____

Accepted for Investigation:

☐ Yes ☐ No ☐ Unknown

Date: _____ Time: _____

Name: _____

Or

DCBS Central intake email only if between the hours of 8am-4:30pm, Mon-Fri., No holidays.

Briefly describe what happened: (Use the first and last name(s) of any staff involved)

Critical Incident Form Follow-Up

(ABI, ABI-LT, HCB, MPW, SCL, SGF)

Individual's Name: _____ Incident Date: _____

1) What is the person's current status? (Choose one) *Use space below to provide detail

- ☐ Stable with no serious changes noted.
- ☐ Seen by professional and returned home.
- ☐ Seen by professional and admitted to facility.(Specify location & date below)
- ☐ Other, Briefly describe:

2) Why did the critical incident occur? (Choose one) *Use space below to provide detail

- ☐ Failure to follow Crisis Support Plan and/or Behavior Support Plan.
- ☐ Unable to determine.
- ☐ Other, Briefly describe:

3) Could this critical incident have been prevented? ☐ Yes ☐ No *Use space below to provide detail

If yes, then how could the critical incident have been prevented? (Choose one)

- ☐ Track/monitor medical treatment. (ER, doctor, hospital, etc.)
- ☐ Ensure timely implementation of current Crisis Support Plan.
- ☐ Track/monitor previous critical incidents.
- ☐ Other, Briefly describe:

4) Were staff training needs identified? ☐ Yes ☐ No

If yes, then identify: (Choose all that apply)

- ☐ Person-specific training. For example, dining plan, positioning, etc.
- ☐ Abuse/Neglect/Exploitation prevention and reporting.
- ☐ Failure to follow agency Policies and Procedures.
- ☐ Crisis Prevention.
- ☐ Medication administration.

5) Identify needed changes to prevent similar critical incidents. (Choose all that apply) *Use space below to provide detail

- ☐ Watch more for advance signs of and triggers for the incident.
- ☐ Improve communication within the agency and between agencies.
- ☐ Other, Briefly describe:
- ☐ Team Meeting.
- ☐ Agency processes/procedures improvements.

Submitted By:					
Printed Name/Title:		Signature:		Date:	
Additional Signatures:					
Printed Name/Title:		Signature:		Date:	
Printed Name/Title:		Signature:		Date:	