

BHO Adverse Incident Report Form: CHP FBHPartners NBHP

*Routing: *Please Fax to Quality Management Department (719) 538-1456*

Client Name:	Client Number:	DOB:
Provider:	Medicaid Number:	
	Not Medicaid (Do not route to BHO): <input type="checkbox"/>	
MH Center Name:	DSM Diagnostic Code(s):	Axis I: Axis II:
Provider Telephone Number:	Axis III:	

Race/Ethnicity Caucasian Hispanic African American American Indian Asian/Pacific Islander Other:

Date of Incident	Incident Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Discovery Date:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Was client enrolled at the time of incident: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Persons Involved Names: <input type="checkbox"/> Clinician/Staff <input type="checkbox"/> Other	Specific Location of the Incident: <input type="checkbox"/> Home <input type="checkbox"/> ATU <input type="checkbox"/> RTC <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient Treatment Setting <input type="checkbox"/> Other (Please Specify):
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Class of Incident (Please check one of the following):

Sentinel Event Incidents that are considered catastrophic in nature including; Unanticipated death of patient/client or treatment staff as the result of violence, accident, or treatment error. Example: suicide/homicide, sexual behavior involving staff, and acts of attempted or actual sexual acts or assaults, rape or attempted rape of patient/client or staff (**Report to BHO or ValueOptions CO within 24 Hours**).

Major Risk Adverse Incident Actual or potential life threatening injury i.e., attempted suicide/homicide. Threat of major permanent loss of physical or psychological function, or major property damage. Example: Suicide attempt requiring urgent/emergent medical care, or assault/fight in treatment setting requiring urgent/emergent care (**Report to BHO or ValueOptions CO within 24 Hours**).

Moderate Risk Adverse Incident Poses substantial risk, or potential risk to client/patient safety. Example: Suicide attempt while in behavioral health treatment setting, not requiring urgent/emergent care, or assault/fight not in behavioral health treatment setting, requiring urgent/emergent care (**Report to BHO or ValueOptions CO within 10 days**).

Minimal Risk Adverse Incident Minimal risk or injury, or potential risk, to client/patient safety. Example: Self-injury, non-lethal intent not resulting in urgent/emergent care, Property Damage less than \$10,000, Medication Error, not requiring urgent/emergent treatment (**Report to BHO within 10 days**).

Type of Incident (Please check one of the following):

<input type="checkbox"/> Unanticipated Death *	<input type="checkbox"/> Sexual Acting Out In A Treatment Setting	<input type="checkbox"/> Elopement
<input type="checkbox"/> Homicide (Sentinel)	<input type="checkbox"/> Fall / Injury In a Treatment Setting	<input type="checkbox"/> Client was Danger to Self or Others
<input type="checkbox"/> Suicide (Sentinel)	<input type="checkbox"/> Violent/Assaultive Behavior	<input type="checkbox"/> Medication Error
<input type="checkbox"/> Natural Causes	<input type="checkbox"/> Requiring Urgent/Emergent Care	<input type="checkbox"/> Adverse Drug Reaction
<input type="checkbox"/> Accidental	<input type="checkbox"/> Allegation of Abuse/Neglect/Exploitation/ Sexual Behavior Involving Staff	<input type="checkbox"/> Breach of Confidentiality
<input type="checkbox"/> Suicide Attempt/Serious Self-Injury*	<input type="checkbox"/> Fire Setting/Property Damage in a Treatment Facility	<input type="checkbox"/> Other (MEDIA EVENTS, DUTY TO WARN, ETC)
<input type="checkbox"/> Non-consensual Sex in A Treatment Setting (Rape Or Attempted Rape)	<input type="checkbox"/> Human/Civil Rights Violation	

* If incident is a suicide, homicide, suicide attempt, or unexpected death, list date of last contact with the client. Date of last contact: _____.

* If the incident was a suicide or suicide attempt, what was the means used: Gun Shot Hanging Overdose Cutting Other: _____

* If the incident was a suicide or suicide attempt, are there previous attempts documented? Yes No How Many? _____

* If the incident was a suicide or suicide attempt, how many previous hospitalizations are documented in the client's file? _____

Was the client discharged from inpatient care or ATU within the last 7 days? Yes No

Was the client discharged from active treatment within the last 90 days? Yes No

As a result of the incident, was client or staff member admitted to a hospital for medical treatment? Yes No

Was the client/staff treated in the emergency room for an injury or condition that could seriously jeopardize their life or health? Yes No

Summary of Incident/Property Damage (Use section on page 2 of this form for additional information if necessary).

Summary of Client Injuries: <input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Summary of Staff Injuries: <input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
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