

CRITICAL INCIDENT REPORT FORM (CIR)

Send typed CIR to MHDDAD-Incidents@dhr.state.ga.us

Incident # _____

Date of Report _____

Date of Incident/Death: _____

Date of Discovery of Incident/Death: _____

Time of Incident/Death: _____

State Hospital reporting: _____

Community Provider reporting: _____

If reporting provider is a subcontractor, who is primary contractor? _____

MHDDAD Region # _____ Person Completing Report _____

Contact Person: _____ Contact Person phone #: _____

Name of site and/or specific location where incident/death occurred (i.e.: Unit name/number, name of PCH, etc): _____

Check appropriate box Community Residential Program Crisis Stabilization Day Program In Community
Local Hospital PRTF Personal Residence Respite State Hospital

Other (please specify): _____

Consumer(s) Information*

Name (first, last) _____ DOB _____ Age at Time of Incident _____ Sex Female Male

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes No CID # _____ SS# _____ Race _____

Admission Date _____ Disability: MH DD AD Check box if consumer directed services

List agency services in which consumer is enrolled:

Treatment required:

None Minor first aid Treatment beyond first aide Medical hospitalization

Brief description of injury:

Name (first, last) _____ DOB _____ Age at Time of Incident _____ Sex Female Male

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes No CID # _____ SS#: _____ Race _____

Admission Date _____ Disability: MH DD AD Check box if consumer directed services

List agency services in which consumer is enrolled:

Treatment required:

None Minor first aid Treatment beyond first aide Medical hospitalization

Brief description of injury:

*Add additional consumers on supplemental form b.1. If supplemental form is used, please check

CRITICAL INCIDENT REPORT FORM (CIR)

Type of Incident

Category I (check all that apply)

Check here if incident is high visibility **

<input type="checkbox"/>	(Allegation of) Consumer to consumer sexual assault or sexual exploitation
<input type="checkbox"/>	(Allegation of) Neglect
<input type="checkbox"/>	(Allegation of) Physical abuse
<input type="checkbox"/>	(Allegation of) Staff to consumer sexual assault or sexual exploitation
<input type="checkbox"/>	Death (please complete death section) Notify Incident Management & Investigations Section at 404-657-1139
<input type="checkbox"/>	Medication errors with adverse consequences
<input type="checkbox"/>	Seclusion/restraint resulting in injury requiring treatment beyond first aid
<input type="checkbox"/>	Suicide attempt that results in medical hospitalization

Category II (check all that apply)

Check here if incident is high visibility **

<input type="checkbox"/>	(Allegation of) Verbal abuse
<input type="checkbox"/>	(Allegation of) Financial exploitation
<input type="checkbox"/>	Consumer injury requiring treatment beyond first aid
<input type="checkbox"/>	Consumer to consumer assault resulting in injury requiring treatment beyond first aid
<input type="checkbox"/>	Consumer to consumer assault with injury requiring minor first aid
<input type="checkbox"/>	Consumer who is unexpectedly absent from a community residential program or day program
<input type="checkbox"/>	Consumer who leaves the grounds of a state hospital without permission
<input type="checkbox"/>	Criminal conduct by consumer
<input type="checkbox"/>	Incident occurring at provider's site which required intervention of law enforcement services
<input type="checkbox"/>	Medical hospitalization of a consumer of a state hospital or community residential program
<input type="checkbox"/>	Seclusion/restraint resulting in injury requiring minor first aid
<input type="checkbox"/>	Staff injury caused by a consumer requiring treatment (State operated programs only)
<input type="checkbox"/>	Vehicular accident with injury while consumer is in a state vehicle or is being transported by community or hospital staff
<input type="checkbox"/>	Incident that does not meet Category I or II criteria

Check here if incident is high visibility **

Brief description of incident-(include who; what; where; when; how; and any precipitating factors that may have contributed to the event, including any medical conditions that have been diagnosed; also include steps taken by facility to prevent further incidents)-

****Notify Incident Management & Investigations Section at 404-657-1139 for High Visibility Incidents**

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Person(s) of Interest

Name	Contact #	Date of Birth
_____	_____	_____
Name	Contact #	Date of Birth
_____	_____	_____
Name	Contact #	Date of Birth
_____	_____	_____
Name	Contact #	Date of Birth
_____	_____	_____

Staff Injured (State operated programs only)

Name	DOB	Contact #	Description of Injury
_____	_____	_____	_____
Name	DOB	Contact #	Description of Injury
_____	_____	_____	_____
Name	DOB	Contact #	Description of Injury
_____	_____	_____	_____
Name	DOB	Contact #	Description of Injury
_____	_____	_____	_____

Witnesses to Incident

Name	Contact #	Staff <input type="checkbox"/>	Consumer <input type="checkbox"/>	Other <input type="checkbox"/>
_____	_____			
Name	Contact #	Staff <input type="checkbox"/>	Consumer <input type="checkbox"/>	Other <input type="checkbox"/>
_____	_____			
Name	Contact #	Staff <input type="checkbox"/>	Consumer <input type="checkbox"/>	Other <input type="checkbox"/>
_____	_____			
Name	Contact #	Staff <input type="checkbox"/>	Consumer <input type="checkbox"/>	Other <input type="checkbox"/>
_____	_____			
Name	Contact #	Staff <input type="checkbox"/>	Consumer <input type="checkbox"/>	Other <input type="checkbox"/>
_____	_____			
Name	Contact #	Staff <input type="checkbox"/>	Consumer <input type="checkbox"/>	Other <input type="checkbox"/>
_____	_____			

Notifications

Agency	Name	Date	Time	Method of Notification
Adult Protective Services				
CPS/DFCS				
Office of Regulatory Services				
Support Coordinator/Broker				
Family/Legal Guardian				
Other				
Other				
Other				
Other				
Other				

Deaths (if applicable)

How was death discovered?

Date of last contact with consumer: _____ Reason for last contact: _____

Was death expected? Yes No Was death an accident? Yes No

Possible suicide? Yes No Possible Homicide? Yes No

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Death Factors (check all that apply)

Accidents Bowel Obstruction Cancer Cerebrovascular disease (stroke) Choking Chronic Liver Disease
 Chronic Lower Respiratory Disease Diabetes Diseases of Heart Hypertension Medication-Related
 Pneumonia/Influenza Septicemia Suicide Unknown

Has autopsy been ordered? Yes <input type="checkbox"/> No <input type="checkbox"/>	If not state reason:
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Cause of death, when known:

Were there unusual circumstances surrounding death? Yes No If yes, please describe below

Medications given to consumer one (1) week prior to the point of death

Medication	Dose	Route	Frequency

Administrator's Review for all critical incidents

State Hospital/Community provider staff/title: _____

Date: _____

By checking this box, I attest that the above entry for State hospital/community provider staff/title verifies my review of the incident.