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 ☐

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Type of Incident

Category I *(check all that apply)* **Check here if incident is high visibility ☐ ****

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

Category II *(check all that apply)* **Check here if incident is high visibility ☐ ****

☐	(Allegation of) Verbal abuse
☐	(Allegation of) Financial exploitation
☐	Consumer injury requiring treatment beyond first aid
☐	Consumer to consumer assault resulting in injury requiring treatment beyond first aid
☐	Consumer to consumer assault with injury requiring minor first aid
☐	Consumer who is unexpectedly absent from a community residential program or day program
☐	Consumer who leaves the grounds of a state hospital without permission
☐	Criminal conduct by consumer
☐	Incident occurring at provider's site which required intervention of law enforcement services
☐	Medical hospitalization of a consumer of a state hospital or community residential program
☐	Seclusion/restraint resulting in injury requiring minor first aid
☐	Staff injury caused by a consumer requiring treatment **(State operated programs only)**
☐	Vehicular accident with injury while consumer is in a state vehicle or is being transported by community or hospital staff
☐	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 ☐ Consumer ☐ Other ☐

Name _____ **Contact #** _____ Staff ☐ Consumer ☐ Other ☐

Name _____ **Contact #** _____ Staff ☐ Consumer ☐ Other ☐

Name _____ **Contact #** _____ Staff ☐ Consumer ☐ Other ☐

Name _____ **Contact #** _____ Staff ☐ Consumer ☐ Other ☐

Name _____ **Contact #** _____ Staff ☐ Consumer ☐ Other ☐

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 ☐ No ☐	**If not state reason:**

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.**