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):** ☐	
MH Center Name:	**DSM Diagnostic Code(s)** **Axis I:** **Axis II:** **Axis III:**	
Provider Telephone Number:		

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

Date of Incident	**Incident Time:** ☐ **AM** ☐ **PM**	**Discovery Date:**	☐ **Male** ☐**Female**	**Was client enrolled at the time of incident:** ☐ **Yes** ☐ **No**

Persons Involved Names:

☐**Clinician/Staff**

☐**Other**

Specific Location of the Incident:
- ☐ **Home**
- ☐ **ATU**
- ☐ **RTC**
- ☐ **Hospital**
- ☐ **Outpatient Treatment Setting**
- ☐ **Other (Please Specify):**

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):

☐ **Unanticipated Death ***	☐ **Sexual Acting Out In A Treatment Setting**	☐ **Elopement**
☐ Homicide (Sentinel)	☐ **Fall / Injury In a Treatment Setting**	☐ Client was Danger to Self or Others
☐ Suicide (Sentinel)	☐ **Violent/Assaultive Behavior**	☐ **Medication Error**
☐ Natural Causes	☐ Requiring Urgent/Emergent Care	☐ **Adverse Drug Reaction**
☐ Accidental	☐ **Allegation of Abuse/Neglect/Exploitation/ Sexual Behavior Involving Staff**	☐ **Breach of Confidentiality**
☐ **Suicide Attempt/Serious Self-Injury***	☐ **Fire Setting/Property Damage in a Treatment Facility**	☐ **Other** (MEDIA EVENTS, DUTY TO WARN, ETC)
☐ **Non-consensual Sex in A Treatment Setting (Rape Or Attempted Rape)**	☐ **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: ☐**None** ☐ **Minimal** ☐ **Moderate** ☐**Severe**

Summary of Staff Injuries: ☐ **None** ☐ **Minimal** ☐ **Moderate** ☐ **Severe**

Over→

Summary of actions taken by provider/MH staff member: Initial and date each action completed:

Date	Initials		Date	Initials		
_____	_____	**Notified 911**	_____	_____	**MD/Primary Therapist Notified**	_____ **Other: Explain in space below.**
_____	_____	**Notified supervisor**	_____	_____	**Notified Mental Health Services**	
_____	_____	**Taken to physician**	_____	_____	**Notified Parent or next of Kin**	
_____	_____	**Taken to hospital**	_____	_____	**Staff Debriefing**	
_____	_____	**Notified health department**	_____	_____	**First Aid Administered to Client**	
_____	_____	**Notified BHO**	_____	_____	**First Aid Administered to Staff**	
_____	_____	**Reported to Social Services**	_____	_____	**Modification of Policy**	

Print Name of Person Submitting Report	Signature	Title	Date & Time Report Completed

FOLLOW UP ***This Report Will Be Reviewed by the Person(s) and Committee(s) Responsible for Facility Safety and Others as Designated***

	Print Name	Signature	Title	Date
Initial Reviewer:				
Second Reviewer:				
Third Reviewer:				

Summary of Follow-Up Activity: ☐ **Staff Debriefing** ☐ **Staff Education** ☐ **Review of Tx Plan** ☐ **Modification of Tx Plan**

☐ **Other – explain:** ____________________

Print Name of Follow Up Coordinator	Signature of Follow Up Coordinator	Title	Date Follow Up Completed

Additional Summary Continued From Page 1: