PerformCARE

Critical Incident Report

Date of Report:_____

Name of Member (Last, First, MI) MA Identifier Number	Provider Name Promise Number/Type
Member Address, including County	Provider Address Level of Care
Member Telephone	Provider Contact Name and Telephone Number
Date of Birth	Date of Admission and Discharge (if Applicable)
Location of Incident and Provider Staff Involved	Date of Incident Time of Incident

Check type of Incident *(Please refer to PerformCare Policy PR-008 Critical Incident Reporting for Definitions)*

- ❑ Suicide attempt
  Was the Member assessed by crisis or nurse?
  ❑ Yes ❑ No
- ❑ Medication error
  Was the Member assessed by a nurse?
  ❑ Yes ❑ No
- ❑ Any event requiring the services of the fire department, or law enforcement agency
- ❑ An injury or illness (non-psychiatric) of a Member requiring medical treatment more intensive than first aid
- ❑ A Member who is out of contact with staff for more than 24 hours without prior arrangement, or a Member who is in immediate jeopardy because he/she is missing for any period of time
  Was the Member assessed by crisis or nurse?
  ❑ Yes ❑ No
- ❑ Abuse or alleged abuse involving a Member
  - ❑ Family
  - ❑ Peer
  - ❑ Staff
  - ❑ Other
- ❑ Seclusion
- ❑ Restraint
  ❑ Chemical ❑ Mechanical ❑ Manual
  Was the Member injured as part of a restraint?
  ❑ Yes ❑ No
  Was the Member assessed by a nurse?
  ❑ Yes ❑ No
- ❑ Death of a Member
- ❑ Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter in place or relocation of residents
- ❑ Provider Preventable Conditions (PPC)
  Was the Member assessed by crisis or nurse?
  ❑ Yes ❑ No
- ❑ Other incident identified by Provider as Critical, Adverse, or Unusual. Please specify:
  - ❑ Physical aggression
  - ❑ Inpatient hospitalization
  - ❑ Self-injurious behaviors
  - ❑ Other:

Describe what happened and any circumstances that may have precipitated the incident. ***Use additional sheets if necessary***.

Outcome/Resolution of event: ***Use additional sheets if necessary.***

Treating Physician's Name and Statement (if applicable)

What action has been taken to prevent reoccurrence? ***Use additional sheets if necessary.***

Mandatory Notification Completed: ❑ Child Line ❑ Older Adults Protective Services ❑ Other: ❑ County_____	Name of County Representative Notified & Office: Name of Relative or Guardian Notified & Relationship:
Submitted by: Name Title	Signature and Date