



**DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH (DSAMH)
INCIDENT/DEATH REPORTING FORM**

Please Print or Type on this Form.

THIS REPORT IS AN GENERAL INCIDENT CRITICAL INCIDENT (PM46 form will need to be completed when applicable)
 DEATH (DHSS Death reporting form will also need to be completed)

Send all Incident and Death reports to complaintandincidentreporting@delaware.gov

Section 1: Location of Event

Residential Non-residential IMD ACT Team ICM Team CRISP Outpatient PHP Group Home Other:

Provider (s) Name:

Provider (s) Address:

Provider (s) Phone Number:

Location of Incident:

Date and Approximate Time of Incident:

Section 2: Person(s) Involved

Check One: Client Staff	Refer As:	Last Name	First Name	Staff Title	Alleged Offender	Alleged Victim	Involved	Witness	Injury
<input type="checkbox"/> <input type="checkbox"/>	Person 1				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	Person 2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	Person 3				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Client's Information

Name of Client (s):

Client (s) Complete Address:

Client (s) Phone Number:

Gender:

DOB:

Race/Ethnicity:

Diagnosis (if known):

Medical Conditions (if known):

Date of Admission:

Date of Discharge (if applicable):



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Section 4: Nature Critical Incident (check all that apply)

**An Incident of Abuse, Neglect, Mistreatment, Financial Exploitation and/ or Significant Injuries That Requires Reporting and Investigative Processes.
Adverse Events (Long Term Care Reporting Required)**

Physical Abuse: includes but not limited to	Emotional Abuse: includes but not limited to	Neglect: includes but not limited to	Mistreatment: includes but not limited to	Financial Exploitation: includes but not limited to	Significant Injury: includes but not limited to
<input type="checkbox"/> Striking or Hitting <input type="checkbox"/> Shoving or Slapping <input type="checkbox"/> Kicking <input type="checkbox"/> Pinching <input type="checkbox"/> Hair Pulling <input type="checkbox"/> Use of an object <input type="checkbox"/> Sexual Contact <input type="checkbox"/> Smashing things <input type="checkbox"/> Inappropriate Use of restraint or seclusion <input type="checkbox"/> Use of restraint/ seclusion <input type="checkbox"/> Restrictive Interventions <input type="checkbox"/> Other: _____ _____ _____	<input type="checkbox"/> Ridiculing or demeaning <input type="checkbox"/> Making derogatory remarks about a client. <input type="checkbox"/> Cursing directed towards a client <input type="checkbox"/> Threatening to inflict physical or emotional harm on a client or themselves <input type="checkbox"/> Ignoring a client in need of help <input type="checkbox"/> Name Calling <input type="checkbox"/> Using looks or actions or speaking in ways which are frightening <input type="checkbox"/> Other: _____ _____ _____	<input type="checkbox"/> Lack of attention to physical needs <input type="checkbox"/> Failure to report health problems. <input type="checkbox"/> Failure to carry out a prescribed treatment plan. <input type="checkbox"/> Putting a client at risk by allowing unsafe choices <input type="checkbox"/> Failure to maintain 1:1 or 2:1 <input type="checkbox"/> Failure to monitor in restraints <input type="checkbox"/> Failure to adhere to CMS/ TJC standards for restraints <input type="checkbox"/> Any act that will cause delay in TX. Or delay in referring to ER <input type="checkbox"/> Failure to follow safety procedures <input type="checkbox"/> Other: _____ _____ _____	<input type="checkbox"/> Inappropriate use or Careless monitoring of medication. <input type="checkbox"/> Inappropriate use of Isolation. <input type="checkbox"/> Inappropriate use of chemical restraints. <input type="checkbox"/> Providing care that is not discussed with client <input type="checkbox"/> Other: _____ _____ _____	<input type="checkbox"/> Theft of money or property <input type="checkbox"/> Use of client's money without client's permission <input type="checkbox"/> Mishandling clients' money or property <input type="checkbox"/> Providing favors in exchange for money, work or sexual favors. <input type="checkbox"/> Failure to notify authorities when others take advantage <input type="checkbox"/> Criminal victimization <input type="checkbox"/> Other: _____ _____ _____	<input type="checkbox"/> One that is life threatening. <input type="checkbox"/> One that causes severe disfigurement. <input type="checkbox"/> One that causes impairment of body organs <input type="checkbox"/> One that causes emotional distress Where outcomes can be measured. <input type="checkbox"/> An injury that causes Need for ER TX. <input type="checkbox"/> All unexpected or unanticipated Deaths. <input type="checkbox"/> Events that involve harm or risk of harm <input type="checkbox"/> Falls w Injury <input type="checkbox"/> Other: _____ _____ _____



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Section 5: Nature of General Incident

Medication Error: includes but not limited to	Hospitalization	Emergency Department	Other	Incident Cause Provider Response
<input type="checkbox"/> Wrong Medication <input type="checkbox"/> Wrong Dose <input type="checkbox"/> Wrong Time <input type="checkbox"/> Omission and Missed Dose <input type="checkbox"/> Wrong Route <input type="checkbox"/> Wrong Count for Controlled Drugs <input type="checkbox"/> Threatened Health & Safety <input type="checkbox"/> Refusal of meds <input type="checkbox"/> Theft of Meds <input type="checkbox"/> Other	<input type="checkbox"/> Medical Hospitalization <input type="checkbox"/> Psychiatric Hospitalization <input type="checkbox"/> Other Name of Hospital: <hr/>	<input type="checkbox"/> Discharged to Home <input type="checkbox"/> Admitted to Hospital Name of Hospital: <hr/>	<input type="checkbox"/> Other reasons for General Incident (Describe Below)	<input type="checkbox"/> Non-adherence to meds or treatment <input type="checkbox"/> Lack of supervision <input type="checkbox"/> Lack of Knowledge <input type="checkbox"/> Resource Utilization Issue <input type="checkbox"/> Inadequate Supports <input type="checkbox"/> Expected course of Disease <input type="checkbox"/> Other Please Explain: <hr/> <hr/>

Section 6: Nature of Death (Check all that apply above) When applicable PM 65 will need to be completed along with Death reporting form.

Anticipated
 Unanticipated
 Accident
 Suicide
 Homicide
 Undetermined
 Natural
 Other _____

Section 7: Incident Description

Describe what happened in detail, including any event leading up to or resulting from the incident (Attach additional information if needed)

Print Name and Title:	Signature:	Date:	Time:
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Section 7: Notifications			
Who:	By Whom:	Date/Time:	
Family Notified <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Program Director/Supervisor Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Law Enforcement notified (if applicable): <input type="checkbox"/> Yes <input type="checkbox"/> No			
Section 8: Immediate Action(s) Taken			
<input type="checkbox"/> Seen by MD	<input type="checkbox"/> Seen at ER	<input type="checkbox"/> Called Crisis	<input type="checkbox"/> Called 911/Emergency Services
		<input type="checkbox"/> Called Adult Protective Services	
Section 9: DSAMH USE ONLY			
Received by DSAMH Quality Assurance and Risk Management Unit: Name: _____ Date/Time: _____			
DSAMH Forwarded to:	Name	Date	Time
DSAMH Executive Director:			
DSAM Medical Director:			
DSAMH Director Community MH and Addiction Services:			
DSAMH Provider Relations:			