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	Alleged Offender	Alleged Victim	Involved	Witness	Injury
☐	☐	Person 1			☐	☐	☐	☐	☐
☐	☐	Person 2			☐	☐	☐	☐	☐
☐	☐	Person 3			☐	☐	☐	☐	☐

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**
☐ Striking or Hitting ☐ Shoving or Slapping ☐ Kicking ☐ Pinching ☐ Hair Pulling ☐ Use of an object ☐ Sexual Contact ☐ Smashing things ☐ Inappropriate Use of restraint or seclusion ☐ Use of restraint/ seclusion ☐ Restrictive Interventions ☐ Other: _____ _____ _____	☐ Ridiculing or demeaning ☐ Making derogatory remarks about a client. ☐ Cursing directed towards a client ☐ Threatening to inflict physical or emotional harm on a client or themselves ☐ Ignoring a client in need of help ☐ Name Calling ☐ Using looks or actions or speaking in ways which are frightening ☐ Other: _____ _____ _____	☐ Lack of attention to physical needs ☐ Failure to report health problems. ☐ Failure to carry out a prescribed treatment plan. ☐ Putting a client at risk by allowing unsafe choices ☐ Failure to maintain 1:1 or 2:1 ☐ Failure to monitor in restraints ☐ Failure to adhere to CMS/ TJC standards for restraints ☐ Any act that will cause delay in TX. Or delay in referring to ER ☐ Failure to follow safety procedures ☐ Other: _____ _____ _____	☐ Inappropriate use or Careless monitoring of medication. ☐ Inappropriate use of Isolation. ☐ Inappropriate use of chemical restraints. ☐ Providing care that is not discussed with client ☐ Other: _____ _____ _____	☐ Theft of money or property ☐ Use of client's money without client's permission ☐ Mishandling clients' money or property ☐ Providing favors in exchange for money, work or sexual favors. ☐ Failure to notify authorities when others take advantage ☐ Criminal victimization ☐ Other:_____ _____ _____	☐ One that is life threatening. ☐ One that causes severe disfigurement. ☐ One that causes impairment of body organs ☐ One that causes emotional distress Where outcomes can be measured. ☐ An injury that causes Need for ER TX. ☐ All unexpected or unanticipated Deaths. ☐ Events that involve harm or risk of harm ☐ Falls w Injury ☐ 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**
☐ Wrong Medication ☐ Wrong Dose ☐ Wrong Time ☐ Omission and Missed Dose ☐ Wrong Route ☐ Wrong Count for Controlled Drugs ☐ Threatened Health & Safety ☐ Refusal of meds ☐ Theft of Meds ☐ Other	☐ Medical Hospitalization ☐ Psychiatric Hospitalization ☐ Other Name of Hospital: _____	☐ Discharged to Home ☐ Admitted to Hospital Name of Hospital: _____	☐ Other reasons for General Incident (Describe Below)	☐ Non-adherence to meds or treatment ☐ Lack of supervision ☐ Lack of Knowledge ☐ Resource Utilization Issue ☐ Inadequate Supports ☐ Expected course of Disease ☐ Other Please Explain: _____

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 ☐ **Yes** ☐ **No**		
Physician Notified: ☐ **Yes** ☐ **No**		
Program Director/Supervisor Notified: ☐ **Yes** ☐ **No**		
Law Enforcement notified (if applicable): ☐ **Yes** ☐ **No**		

Section 8: Immediate Action(s) Taken			
☐ **Seen by MD** ☐ **Seen at ER**	☐ **Called Crisis**	☐ **Called 911/Emergency Services**	☐ **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:			