Event # _____ DMH Use Only

Print Form

Please note all signatures are required to be original signatures. Please complete the form electronically, print, sign and submit to the department.

Department of Mental Health
EMT - Community Event Report Form - ADA/CPS

Division (please select one): ☐ Alcohol and Drug Abuse (ADA) ☐ Comprehensive Psychiatric Services (CPS)

1. EVENT DATE & TIME: _____ _____ ☐ AM ☐ PM

2. DISCOVERY DATE & TIME: _____ _____ ☐ AM ☐ PM

3. EVENT LOCATION OR WHERE DISCOVERED:
(Name of agency or location)

4. NAME OF PERSON/AGENCY INVOLVED IN EVENT:

Vendor Number *(required)* _____

5. EVENT CATEGORY: (Check One) ☐ **INCIDENT (Includes Death)** ☐ **MEDICATION ERROR**

6. PROGRAM CATEGORY PERTINENT TO EVENT:

ADA Only: ☐ **Adult or** ☐ **Adolescent** **Choose a service type:** _____

CPS Only: ☐ **Adult or** ☐ **Youth** **Choose a service type:** _____

7. REPORTABLE EVENT: All events identified below shall be recorded on this form and faxed within one (1) business day to the appropriate division, *Division of Alcohol and Drug Abuse District Administrator* or the *Division of Comprehensive Psychiatric Services Supported Community Living Office*.

☐ Death (All deaths, including those of consumers within 30 days post-discharge from residential programs.) **If checked complete suspected manner (14)**

☐ Injury resulting in medical inpatient hospitalization. **If checked, please complete 9, 10, and 11.**

☐ Elopement/ Unauthorized Absence (When absence raises reasonable concern for the safety of the consumer or others, or the consumer will not return. For ADA, this applies to adolescents and involuntary commitments only.) Return Date: _____ Time: _____ ☐ AM ☐ PM

☐ **MEDICATION ERROR**(Occurring in residential programs or programs in which medication is administered or self administration is observed by the agency.)

Severity: *(SELECT ONE)*

☐ Moderate: Treatment and/or interventions in addition to monitoring or observation

☐ **Serious:** Life threatening and/or permanent adverse consequences

Medication Error Category:

☐ **Failure to Administer**

Reason: _____

☐ **Wrong Form**
☐ **Wrong Medication**
☐ **Wrong Person**
☐ **Wrong Dose**
☐ **Wrong Route**
☐ **Wrong Time**
☐ **No Physician Order**

☐ **Alleged or Suspected Abuse, Neglect, or Misuse of Funds/Property**

Select Type: (all that apply) ☐ Verbal Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐ Neglect ☐ Misuse of Funds/Property

If Physical Abuse, Verbal Abuse, Sexual Abuse, Misuse of Consumer Funds/Property or Neglect is alleged by a consumer or suspected by staff, report this immediately by verbal or written report and follow all other procedures described in 9 CSR 10-5.200.

8. PERSONS INVOLVED : Please PRINT (attach pages if necessary)	**Relationship**	**Role**	**DMH State #** (for consumers)	**Date of last Services** (for consumers)

Relationship Types: Consumer, Parent, Guardian, Staff, Visitor, Volunteer, Other (PLEASE SPECIFY)
Role Types: Complainant, Perpetrator, Victim, Witness, Other (PLEASE SPECIFY)

9. INJURY TYPE *(SELECT ONE)* ☐ Accident ☐ Consumer Inflicted ☐ Other Inflicted ☐ Self Inflicted ☐ Staff Inflicted ☐ Unknown

10. INJURY DESCRIPTION *(CHECK ALL THAT APPLIES)*

- ☐ Abrasion
- ☐ Bite
- ☐ Burn
- ☐ Complaint of Pain
- ☐ Contusion/Bruise
- ☐ Dislocation
- ☐ Fracture/Break
- ☐ Frostbite
- ☐ Heat related illness
- ☐ Laceration/Cut
- ☐ Puncture
- ☐ Scratches
- ☐ Strain/Sprain
- ☐ Swelling
- ☐ Other (Specify)

11. INJURED BODY PARTS *(CHECK ALL THAT APPLY)*

- ☐ Head
- ☐ Face
- ☐ Eye - Right
- ☐ Eye - Left
- ☐ Ear - Right
- ☐ Ear - Left
- ☐ Nose
- ☐ Mouth
- ☐ Teeth
- ☐ Neck
- ☐ Upper Back
- ☐ Chest
- ☐ Shoulder - Right
- ☐ Shoulder - Left
- ☐ Upper Arm - Right
- ☐ Upper Arm - Left
- ☐ Elbow - Right
- ☐ Elbow - Left
- ☐ Forearm - Right
- ☐ Forearm - Left
- ☐ Wrist - Right
- ☐ Wrist - Left
- ☐ Hand - Right
- ☐ Hand - Left
- ☐ Lower Abdomen
- ☐ Waist
- ☐ Hip - Right
- ☐ Hip - Left
- ☐ Genitials
- ☐ Buttock - Right
- ☐ Buttock - Left
- ☐ Thigh - Right
- ☐ Thigh - Left
- ☐ Knee - Right
- ☐ Knee - Left
- ☐ Calf - Right
- ☐ Calf - Left
- ☐ Shin - Right
- ☐ Shin - Left
- ☐ Ankle - Right
- ☐ Ankle - Left
- ☐ Foot - Right
- ☐ Foot - Left

Other:

FINGERS ☐ Thumb - Right ☐ Thumb - Left ☐ Index - Right ☐ Index - Left ☐ Middle - Right ☐ Middle - Left ☐ Ring - Right ☐ Ring - Left ☐ Little - Right ☐ Little - Left

TOES ☐ Big - Right ☐ Big - Left ☐ 2nd - Right ☐ 2nd - Left ☐ 3rd - Right ☐ 3rd - Left ☐ 4th - Right ☐ 4th - Left ☐ Little - Right ☐ Little - Left

☐ **Event or** ☐ **Discovery Date and Time** ☐ AM ☐ PM

12. NOTIFIED:	Name of Person Contacted	Date	Time
☐ **Family or Guardian**			☐ AM ☐ PM
☐ **Physician**			☐ AM ☐ PM
☐ **Law Enforcement**			☐ AM ☐ PM
☐ **Dept. of Mental Health**			☐ AM ☐ PM
☐ **DSS Children's Division**			☐ AM ☐ PM
☐ **DHSS**			☐ AM ☐ PM
☐ **911**			☐ AM ☐ PM
☐ **Other (Coroner or M.E.)**			☐ AM ☐ PM
☐ **Other**			☐ AM ☐ PM
☐ **Other**			☐ AM ☐ PM
☐ **Other**			☐ AM ☐ PM

13. EVENT DESCRIPTION: Describe what happened and interventions used by staff.

Attach additional pages if necessary.

14. IMMEDIATE ACTION TAKEN BY AGENCY AND ACTION STEPS TO PREVENT REOCCURANCE: (To be completed by agency management if action was required.)

If a death occurred: Suspected Manner of Death ☐ **ACCIDENT** ☐ **HOMICIDE** ☐ **NATURAL** ☐ **SUICIDE** ☐ **UNDETERMINED**

Is an Autopsy being performed? ☐ **YES** ☐ **NO** ☐ **UNKNOWN**

If Yes, list Coroner/ Medical Examiner:

15. SIGNATURE - REPORTER:

Agency Name:

Reporter's Signature:

Print Reporter's Name:

Date Reporter Signed:

Phone Number:

*****Please note all signatures are required to be original signatures. Please complete the form electronically, print, sign and submit to the department.*****

To be Completed by Department of Mental Health Staff

16. ACTION/ COMMENTS

Incident Type:

- ☐ Consumer Self Harm
- ☐ Violation of Consumer Rights
- ☐ Consumer struck object resulting i in injury
- ☐ Fall
- ☐ Fire
- ☐ In appropriate language by staff toward consumer
- ☐ Medical emergency-Consumer
- ☐ Misuse of consumer funds/property
- ☐ Physical altercation-between consumers
- ☐ Physical altercation-consumer & non-staff
- ☐ Physical altercation-Staff & Consumer
- ☐ Possession of Weapon
- ☐ Property loss/destruction
- ☐ Sexual conduct-consumer/non-consensual
- ☐ Sexual conduct-staff & consumer
- ☐ Suicide attempt
- ☐ Theft by consumer
- ☐ Vehicular accident
- ☐ Other

If other selected, please explain:

Was the event a Critical Incident? ☐ **YES** ☐ **NO**

If yes to either question, must be entered into EMT within 24 hours.

Suspicion or Allegation of Abuse, Neglect or Misuse of Consumer Funds/ Property? ☐ **YES** ☐ **NO**

Decision: ☐ Inquiry ☐ Local Review ☐ Death Review ☐ No Action Taken ☐ CO Invesitigation Required

Result: ☐ Accepted ☐ Declined

Notes:

Check any of the following contacts that are required:

☐ **DMH Facility Head** ☐ **Parent/ Guardian** ☐ **Local Law Enforcement** ☐ **DHSS** ☐ **DSS**

Signature of DMH Staff:

Date:

Additional Notes: