Contractor Incident Reporting Form

Client Case #: _____
First Name: _____
Last Name: _____
Client Medicaid #: _____

Client Home Unit:_____
☐ GR ☐ TxHmLv ☐ ICF/MR ☐ HCS

Send completed form to 1300 Circle Drive, FW 76119 Attn: MR/QM Coordinator or fax to 817-569-5474

Date: _____ Time: _____ ▫ AM ▫ PM ▫ Occurred ▫Discovered
Incident Place: _____
Reporting Staff: _____
Reporting Provider: _____
Contact Phone #: _____

Critical Event: (Must be reported within 24 hours of incident to the persons' service coordinator/case manager) **The following should be reported only if the incident directly involves a person who receives services through MHMR of Tarrant County**

- ▫ Death
- ▫ News media coverage likely
- ▫ Missing person (police report filed)
- ▫ Physical restraint
- ▫ Homicide threat with a plan
- ▫ Homicide attempt (by client)
- ▫ Perpetrator of homicide (client)
- ▫ Notification by DFPS of investigation
- ▫ Catastrophic events (bomb , threat, explosion, fire, etc).
- ▫ Litigation threat (client, staff, family/guardian, etc)

Client Related Incident:

- ▫Abuse/neglect/exploitation
- ▫ Suicide attempt
- ▫ Client injury requiring ER
- ▫ Client illness requiring admission
- ▫ Client injury not requiring ER
- ▫ 911 Called
- ▫ Physical aggression
- ▫ Illegal substances
- ▫ Client property/financial loss
- ▫ Medication error
- ▫ Infectious Diseases
- ▫ Work related injury
- ▫ Staff auto accident while transporting MHMR consumer
- ▫ Sexual misconduct
- ▫ Self abusive behavior
- ▫ Psychiatric admission
- ▫ Criminal activity
- ▫ Complaints (clients, family/guardians)
- ▫ Other: _____

Facility Related Incident:

▫ Agency property damage/financial loss ▫ Fire at facility ▫ Other _____

Medication Errors:

Person's involved

▫ Pharmacist _____ ▫ Nurse _____ ▫ Consumer _____

▫ Physician _____ ▫ Staff _____ ▫ Family _____

Medication Error Type:

- ▫ Wrong medication
- ▫ Wrong client
- ▫ Wrong dose
- ▫ Missed dose
- ▫ Wrong time
- ▫ Wrong Route

Total # errored ☐

Description of event/medication error continued: *(For medication errors list the error, name of medication, intended dose, actual dose administered)*

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Event Reporting Form Today's Date: _____

Person/Date/Time of those notified: Last Name: _____ First Name: _____

☐Case Manager/Service Coordinator/QMRP/Supervisor	Date: _____ Time: _____ ☐ AM ☐ PM
☐Home Manager/Habilitation Trainer	Date: _____ Time: _____ ☐ AM ☐ PM
☐Parent/Guardian _____	Date: _____ Time: _____ ☐ AM ☐ PM
☐Psychologist	Date: _____ Time: _____ ☐ AM ☐ PM
☐Nurse _____	Date: _____ Time: _____ ☐ AM ☐ PM
☐Physician _____	Date: _____ Time: _____ ☐ AM ☐ PM
☐QM Coordinator	Date: _____ Time: _____ ☐ AM ☐ PM
☐Program Manager _____	Date: _____ Time: _____ ☐ AM ☐ PM
☐Program Manager _____	Date: _____ Time: _____ ☐ AM ☐ PM

MHMRTC Follow-up Comments and Signatures:

Case Manager/Service Coordinator/QMRP/Supervisor Signature Date

Psychologist/Nurse/Physician Signature Date

Program Manager Signature Date

Program Director Signature Date

Revised 2/29/10