Contractor Incident Reporting Form

Client Case #: __________________
First Name: _____________________
Last Name: _____________________
Client Medicaid #: ______________
Client Home Unit: __________________
□ GR □ TxHmLv □ ICF/MR □ HCS

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

Client Related Incident:

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

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 dose □ Wrong time
□ Wrong client □ Missed dose □ 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

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