**DMHAS CRITICAL INCIDENT SUBMISSION FORM**

* Mental Health PNP Affiliates: Submit this form to designated contact at your LMHA.
* PNP/State Operated LMHAs and Other Mental Health/Substance Use Providers: Use this form to guide data entry into the online Critical Incident Application.
* [**Contact Information**](https://portal.ct.gov/DMHAS_CI_Contacts)for making verbal report

**The Incident**

**Contact Person:** **Contact Phone:**        **Date of Incident:** **Time of Incident:**

**Provider Reporting:       Program Reporting:**

**Location of Incident (CT Town Name or Out of State):**

**Location Type (Check one):**

Client’s Residence

Community *(public location, relative’s home, etc.)*

IP Unit, DMHAS-Operated

IP Unit, DMHAS Funded

Jail

Nursing Home

Program Premises: Non-Inpatient

Other Location

*(please specify)*:

**Incident Category/Subcategory** *(check only one box to indicate a category type for this incident. Description of each subcategory can be found here:* [*https://portal.ct.gov/DMHAS-critical-incidents-definitions*](https://portal.ct.gov/DMHAS-critical-incidents-definitions)*).*

***Client Abuse Alleged***

Physical Abuse

Verbal Abuse

Sexual Abuse

Neglect

Exploitation

***Patient Rights***

Potential violation of patient rights with significant consequences

Potential breach of confidentiality with significant consequences

***Death***

Suicide

Homicide

Accident

Accidental Overdose (resulting in death)

Medical Error

Illness, Age, or Medical Reason

Info Pending / Insufficient Info

***Emergency Evacuation***

Fire

Bomb

Other

***Escape (Forensic only)***

PSRB

DOC

Competency Restoration

***Federal Notification***

Secret Service

FBI

Other Federal Notice

***Medical Event***

Accidental Injury

Accidental Overdose (not resulting in death)

Medication Error/Reaction

Medical Event – Other

***Missing Client***

Missing Inpatient, Risk to Self or Others

Missing Outpatient, Risk to Self or Others

Missing Person

***Property Damage***

Property Damage – Safety Issue

Property Damage

***Serious Crime Alleged***

Physical Assault

Sexual Assault

Risk of Injury to Minor

Arson

Drug Sale / Distribution/Possession

Homicide / Manslaughter

Theft/Burglary

Other Serious Crime (specify):

***Serious Suicide Attempt***

Suicide Attempt while Active in Program

Suicide Attempt within 30 days of Discharge

***Threats***

Threats to Agency

Threats to Person

***Other***

Other Incident (specify):

**Does it appear that one or more of the following substances were a direct cause or contributory cause of the incident?**

Alcohol  Prescribed Medication  Illicit Drug  Over-the-counter Medication  Unknown

**Is there any evidence that the incident may have been a result of an alcohol/drug/medication overdose?**

Yes  No

**Does it appear that the incident is related to restraint or seclusion?**   Yes  No

**Is there evidence that this incident involves domestic/relationship violence?**  Yes  No

**Media Coverage:**  Reported  Possible Report  Unlikely

**Incident Description:**

     **Is this an Agency incident?**  Yes  No If you choose YES, you do not need to fill out the **People** section below

Note: An Agency incident is generally not specific to a particular client, but involves action at the agency level. Example: Evacuation of a residence due to a fire is an Agency level CI (Emergency Evacuation – Fire). If the fire was intentionally set by a client, it would be more appropriate to categorize it as a Client level CI (Serious Crime – Arson), even if it still involved evacuating other clients.

**The People**

**Please fill out a copy of this page for each client/staff/visitor involved in this CI (if more than 2 people please use the Extra Person form)**

**PERSON #1**

**Check one box and follow the instructions**

I am reporting on a CLIENT, **complete questions 1-6**

I am reporting on a STAFF, **complete questions 3, 5 & 6 only**

I am reporting on a VISITOR/OTHER, **complete questions 5-6 only**

**1. Client SSN:**

**2. Client relationship to Agency:**  client – active  former client – non active

**3. Name:**  **4. DOB:**

**5. Role:**  Victim  Perpetrator  NA

**6. Injuries:**

No injury

Death

Medical intervention and/or hospitalization required

Minor injury

Unknown

**PERSON #2 *(skip if incident only involved one person)***

**Check one box and follow the instructions**

I am reporting on a CLIENT, **complete questions 1-6**

I am reporting on a STAFF, **complete questions 3, 5 & 6 only**

I am reporting on a VISITOR/OTHER, **complete questions 5-6 only**

**1. Client SSN:**

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Death

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**The Closure**

**Note: This form may be completed by a person responsible for DDaP reporting in collaboration with program management.**

**Date of Review:**  **Date Closed:**

**Closed by:**

**Primary Review Method:**

Administrative Review

Case conference

Critical Incident Review

Human Resources Review

Other

Root Cause Analysis

**Review Chairperson (if applicable):**

**Review Findings:**

**Corrective Actions (proposed/completed):**

**Did the Incident result in a change of policy?**  Yes  No

**Did the Incident result in a change in clinical practice?**   Yes  No

**Did the Review find that the Incident was substantiated (i.e., was there evidence to support that the incident did occur)?**

Yes  No

\* Required only forClient Abuse Alleged, Patient Rights, and Serious Crime categories **Final Incident Category/Subcategory:** *(check only one box to indicate a category type for this incident – based on the review findings, it may be the same or different from the category selected when the incident was reported). Description of each subcategory can be found here:* [*https://portal.ct.gov/DMHAS-critical-incidents-definitions*](https://portal.ct.gov/DMHAS-critical-incidents-definitions)*).*

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***Threats***

Threats to Agency

Threats to Person

***Other***

Other Incident (specify):

*\* see last question on next page*

**If the Final Incident Category is DEATH (shaded above), please fill out the following information:**

**Cause of Death:** *(choose one)*

Accident

Alzheimer’s Disease

Blood Poisoning (Septicemia)

Cancer

Chronic Lung Disease

Diabetes

Drug Overdose

Heart Disease

Hypertension/Renal Disease

Influenza/Pneumonia

Liver Disease

Nephritis/Kidney Disease

Stroke

Suicide

Unknown

Other (specify):

**Source of Information:** *(choose one)*

Autopsy Report/Medical Examiner

Death Certificate

Evident from Circumstances

Family Report

Media Report

Other (specify):      

Physician/Medical Personnel

Police Report

Provider Report

**Medical Conditions present at Death:** *(choose all that apply)*

AIDS/HIV

Arthritis

Asthma

Cancer

Congestive Heart Failure/Heart Disease/Problems

Chronic Pain

Cirrhosis/Liver Disease

COPD

Diabetes

Emphysema/Lung Disease

GERD

Hepatitis

Hyperlipidemia

Hypertension

Infectious Disease (eg, COVID)

Obesity

Other (specify):

Pneumonia

Renal Failure/Kidney Disease/Infection

Seizure Disorder

Stroke/Aneurism

Thyroid Disease

Traumatic Brain Injury (TBI)

**\*If the Final Subcategory is *Accidental Overdose (resulting in death) OR Accidental Overdose (not resulting in death)*, please fill out the following information:**

**Substances involved in overdose:** *(choose all that apply)*

Alcohol

Amphetamines

Barbiturates

Benzodiazepines

Cocaine

Crack

Hallucinogens: LSD, DMS, STP

Heroin

Inhalants

Marijuana, Hashish, THC

Methamphetamines

Non-prescriptive Methadone

Other (specify):      

Other Opiates and Synthetics

Other Sedatives or Hypnotics

Other Stimulants

Over-The-Counter

PCP

Tranquilizers

Unknown