

MAGELLAN BEHAVIORAL CARE OF IOWA IOWA PLAN CRITICAL INCIDENT REPORT

Please fax to: Magellan Quality Improvement Department at (888) 656-5226 within 24 hours of incident.

Today's Date:

Name/Title of Individual Completing Form:

Provider/Facility Name where incident occurred:

Address: City: Phone:

CLIENT INVOLVED IN INCIDENT

Name: DOB: Medicaid ID/SS #:

Male Female Medicaid Client DPH Client

List any other involved party (i.e. other client, visitor, staff, etc.):

Type of service(s) client is receiving: Mental Health Substance Abuse Both MH and SA

Specify service or level of care (i.e. inpatient, residential, etc.):

NATURE OF INCIDENT

DATE OF INCIDENT:

- Death (i.e. suicide or death from any cause after entry into treatment)
Please specify (suicide, heart attack, stroke, etc.):
- Suicide attempt
- Self-mutilation/Self-assault
- Assault on others
- Other dangerous behavior
- Sexual abuse or allegation thereof (while in treatment setting)
- Use of illicit drugs/alcohol while in an inpatient, residential, or halfway house facility
- Abuse of over-the-counter medications or toxic substances (i.e. glue, inhalants, etc.) while in an inpatient, residential, or halfway house facility
- Leaving a 24-hour facility against medical advice (AMA/ASA)
- Escape from a locked facility
- Unauthorized departure from a 24-hour facility pursuant to a court order
- Adverse incidents related to seclusion and/or restraint (specify problem):
- Other:

Brief description of incident:

Follow-up actions taken by provider (i.e. admitted client to inpatient facility, offered counseling/referral to family, revised policies/procedures):