



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
- Total # errored
- Wrong dose
- Missed dose
- Wrong time
- Wrong Route

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: _____

<input type="checkbox"/> Case Manager/Service Coordinator/QMRP/Supervisor	Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Home Manager/Habilitation Trainer	Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Parent/Guardian _____	Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Psychologist	Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Nurse _____	Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Physician _____	Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> QM Coordinator	Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Program Manager _____	Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Program Manager _____	Date: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> 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