Behavioral Health System
Baltimore

Critical Incident Form

Name of Reporting Agency:

Program Name:

Location/Address of Incident:

When did the incident occur?
Date: Time:

Address: City: State: Zip:

Setting		Residential	Type of Incident
☐ OMHC	☐ OTS	☐ Level 3.1	☐ Death
☐ PRP	☐ IOP 2.1	☐ Level 3.3	☐ Serious Bodily Inj.
☐ RRP	☐ OP Level 1	☐ Level 3.5	☐ Fire
☐ Care Coordination/Targeted Case Mgmt.		☐ Level 3.7	☐ Suicide
☐ Partial Hospitalization Treatment Level 2.5			
☐ Psychiatric Day Treatment Program		☐ Level 3.7D	☐ Suicide Attempt
☐ Mobile Treatment Services Program			☐ Homicide
☐ Group Home			☐ Elopement
☐ Integrated Behavioral Health Program			☐ Missing Person
			☐ Assault
			☐ Medication Error
			☐ Seclusion/Restrict
			Other:

Consumer/Alleged Victim

First Name: Middle Name: Last Name:

Date of Admission: Sex: Age: Race:

Address: City: State: Zip:

Alleged Perpetrator

First Name: Middle Name: Last Name:

Date of Admission: Sex: Age: Race:

Address: City: State: Zip:

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Behavioral Health Diagnosis

Primary

Diagnosis

Diagnosis

Medical Diagnosis

Primary

Diagnosis

Diagnosis

Medications

1.

2.

3.

4.

5.

6.

Endangered Adult or Child Notification Made:

Adult Protective Services (APS) ☐ Yes ☐ No ☐ N/A

Child Protective Services (CPS) ☐ Yes ☐ No ☐ N/A

Date Notified:

Law Enforcement Contact: ☐ Yes ☐ No Hospitalization: ☐ Yes ☐ No

EMT: ☐ Yes ☐ No

Consumer Status:

Date last seen for service:

Precautions prior to this incident:

Precautions initiated after incident:

Significant medical history:

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Medication changes in the last 90 days ☐ **Yes** ☐ **No**

Services Received:

☐ **Individual Therapy** ☐ **Group Therapy** ☐ **Medication Management**

☐ **Case Management** ☐ **ACT/Mobile Crisis** ☐ **Detoxification/inpatient/outpatient**

☐ **Other (Specify):** ______

Last Date of Service: ______ **Type of Service:** ______

Description of Event/Incident(s):

***Instructions*: Please write a detailed concise description that took place including any significant events that led up to the incident. Specify names of those involved including staff related to the event/incident.**

Incident Resolution and/or Agency Plan of Action

Critical Incident Form

Will there be an internal review of this incident by this agency? ☐ **Yes** ☐ **No**

Name of Person Completing Form:

First Name: _____ **Last Name:** _____ **Date:** _____

Title: _____

(Include credentials, if applicable)

Email: _____ **Phone:** _____ **Fax:** _____

Name of Agency Contact for Follow-up:

First Name: _____ **Last Name:** _____ **Date:** _____

Title: _____

(Include credentials, if applicable)

Email: _____ **Phone:** _____ **Fax:** _____

Reviewed by BHSB: Name: _____ **Date:** _____