

**KANSAS HEALTH SOLUTIONS
CRITICAL INCIDENT REPORT FORM**

TRACKING ID (for KHS use only)

INSTRUCTIONS:

1. A KHS-contracted provider must report to KHS any critical incident (listed in Section "Type of Report") involving a KHS member within 24 hours of the time the provider becomes aware of the incident. Such reports must be made using this form.
2. Complete **ALL** sections of this form. This Critical Incident Form can be saved as a blank document in Word for repeated use. If the form is completed manually, please type or print legibly and use additional pages, if necessary.
3. Submit completed form to the KHS Director of Quality Improvement via US Mail or facsimile at (785) 234-2410. Please, do not e-mail.
4. A Supplemental Report Form must be submitted to KHS following subsequent investigation/review, if any.

PROVIDER MAKING REPORT	
Provider Name:	
Address & Phone Number:	
Date of Report:	Date of Incident:

TYPE OF REPORT <i>Check All That Apply</i>	
<input type="checkbox"/>	Member Death <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide (victim) <input type="checkbox"/> Other (specify):
<input type="checkbox"/>	Suicide attempt requiring medical services*
<input type="checkbox"/>	Homicide or attempted homicide alleged to have been committed by a member
<input type="checkbox"/>	Adverse reaction to medication(s) requiring medical services*
<input type="checkbox"/>	Act or omission by provider employee or contractor that falls or may fall below the applicable standard of care or professional obligation <input type="checkbox"/> Medication error(s) requiring medical services* <input type="checkbox"/> Self-inflicted injury occurring on provider premises or during a provider-sponsored activity requiring medical services* <input type="checkbox"/> Improper use and/or physical injury resulting from use of personal or mechanical seclusion or restraint <input type="checkbox"/> Suspected or alleged criminal activity that occurs on the provider premises or during a provider-sponsored activity off-premises <input type="checkbox"/> Other (specify):
<input type="checkbox"/>	Any allegation of abuse, neglect or exploitation of a Member committed by provider employee or contractor, including: <input type="checkbox"/> Sexual relations with a Member <input type="checkbox"/> Financial exploitation of a Member
<input type="checkbox"/>	Any act or series of acts resulting in the significant destruction of provider property committed by a Member.

ENROLLED MEMBER INVOLVED IN INCIDENT				
Member Name:		Member Medicaid ID:		
Age:		Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Current Diagnosis:	Axis I:	Axis II:	Axis III:	
Services Furnished by Provider:	<input type="checkbox"/> Outpatient Therapy	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Rehabilitation Services	<input type="checkbox"/> Other (specify):
Date/Type of Last Service Furnished By Provider:				

INCIDENT DETAILS
Summary of facts relevant to incident:
Medical services furnished to Member in connection with incident (if any):

Clinical Director or Designee's Name, Credential and Title:
Phone Number:
Signature: _____
Date: _____

* "Requiring medical services" means a member requires medical treatment beyond first aid. First aid means medical attention that is usually administered immediately after the injury occurs and at the location where it occurred. It often consists of a one-time, short-term treatment and requires little technology or training to administer, e.g. cleaning and/or bandaging minor cuts, scrapes or scratches.

PROVIDER'S RESPONSE (For KHS Use Only)

Actions taken by Provider:

Recommendations for minimizing future occurrences:

PROVIDER'S RESPONSE (cont.)

FOLLOW-UP REPORT (For KHS Use Only)

Does provider intend to conduct additional investigation/review of incident (check one)? Yes No

If yes, Provider must submit completed Supplemental Incident Report to KHS within three business days of completion of such investigation/review.

Clinical Director or Designee's Name, Credential and Title:

Phone Number:

Signature: _____

Date: _____