# ATTACHMENT DH: Critical Incident Form

**DESIGNATED HOSPITAL REPORT**

**VERMONT DEPARTMENT OF MENTAL HEALTH**

 **INPATIENT SIGNIFICANT EVENT**

The Department of Mental Health is to be notified of a significant event that occurs in a Designated Hospital. A verbal report will be made within 24 hours or one business day to the DMH RN Quality Management Coordinator at 802-595-2444. This completed form must be sent to the Department of Mental Health within 48 hours or 2 business days of the event via secure email AHS.DMHquality@vermont.gov.

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| --- | --- |
| **Patient Name**:       | **Event Date:**       |
| **Date of Birth**       | **Event Time:**       |
| **Admission Date:**       | **Location:**       |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Hospital**:  | [ ]  UVMMC | [ ]  RRMC | [ ]  CVMC | [ ]  WC | [ ]  BR | [ ]  VPCH |

**Type of Event:**

|  |  |
| --- | --- |
| [ ]  APS report | [ ]  Criminal activity/law enforcement on unit |
| [ ]  Patient serious injury/medical event | [ ]  Medication error |
| [ ]  Serious patient injury resulting from phys. assault | [ ]  Death |
| [ ]  Other:       |
| [ ]  Elopement | [ ]  Serious staff injury pursuant to 18 VSA §7257 |

**Is there potential media involvement for this event?**

|  |  |
| --- | --- |
| [ ]  YES | [ ]  NO |

**Persons who witnessed or were involved in the event:**

**Description of event** (identify precipitants, interventions used by staff to attempt to prevent/manage the event, and description of behaviors observed during the event):

**Action(s) taken as a result of the event**:

**Describe any planned follow up in response to the event**:

**Persons and agencies notified** (include when and how notified; if an agency, name of staff to whom report given)

**Person reporting**:

**Phone number:** (**REQUIRED**)

**Date:**