

Department of Mental Health

CIMOR EMT - Community Event Report Form - MRDD

Event # _____
DMH Use Only

1. Event Date & Time ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM Month Day Year	2. Discovery Date & Time ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM (Complete this section only if different than event date/time)
3. Event Location or where discovered (Name of agency or location)	4. Name of Provider Agency/Organization involved in event & VENDOR NUMBER

EVENT CATEGORY (CHECK ONE)	5. <input type="checkbox"/> INCIDENT (Includes Death) <input type="checkbox"/> MEDICATION ERROR
PROGRAM CATEGORY PERTINENT TO EVENT (CHECK ONE)	6. <input type="checkbox"/> CASE MANAGEMENT <input type="checkbox"/> ISL <input type="checkbox"/> GROUP HOME <input type="checkbox"/> PERSONAL ASSISTANT <input type="checkbox"/> SUPPORTED EMPLOYMENT <input type="checkbox"/> DAY HABILITATION <input type="checkbox"/> RESPIRE <input type="checkbox"/> OTHER _____ (please list)

7. EVENT/ INCIDENT TYPE (SELECT ONE BELOW) <input type="checkbox"/> Choking (requiring intervention) <input type="checkbox"/> Ingestion of non-food item <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Violation of Consumer Rights <input type="checkbox"/> Medical emergency-Consumer <input type="checkbox"/> Theft by consumer <input type="checkbox"/> Consumer struck object resulting in injury <input type="checkbox"/> Misuse of consumer funds/property <input type="checkbox"/> Vehicular accident <input type="checkbox"/> Elopement when absence raises reasonable concern for the safety of consumer or others, or concern the consumer will not return <input type="checkbox"/> Physical altercation-between consumers <input type="checkbox"/> Other _____ Return Date: _____ Time ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Found on Floor/ground (not witnessed) <input type="checkbox"/> Possession of weapon <input type="checkbox"/> Fall to floor/ground (witnessed) <input type="checkbox"/> Property loss/destruction <input type="checkbox"/> Near Fall (lowered to floor by staff) <input type="checkbox"/> Sexual conduct-consumer/non-consensual <input type="checkbox"/> Fire <input type="checkbox"/> Sexual conduct-staff & consumer <input type="checkbox"/> Inappropriate language by staff toward consumer	8. DID THE EVENT RESULT IN Check all that apply <input type="checkbox"/> Injury to consumer <input type="checkbox"/> Use of physical restraint <input type="checkbox"/> Administration of PRN psychotropic medication <input type="checkbox"/> Hospitalization/non-injury <input type="checkbox"/> Death <input type="checkbox"/> None of the above If injury complete 10, 11 12, 13
---	--

9. Persons Involved (attach pages if necessary)	Relationship	Role	DMH State ID # (for consumers)

Relationship Types: Consumer, Parent, Guardian, Staff, Visitor, Volunteer, Other – specify (list consumer name(s) first and repeat first ID at top of page 2)
Role Types: Alleged Perpetrator (or Responsible Party), Alleged Victim, Complainant, Informant, Witness, Other- specify, (reporter listed in section 19)

10. INJURY TYPE (SELECT ONE) <input type="checkbox"/> Accident <input type="checkbox"/> Consumer Inflicted <input type="checkbox"/> Self Inflicted <input type="checkbox"/> Staff inflicted <input type="checkbox"/> Other Inflicted <input type="checkbox"/> Unknown			
11. INJURY SEVERITY (SELECT ONE) <input type="checkbox"/> No Treatment <input type="checkbox"/> Minor First Aid <input type="checkbox"/> Medical Intervention <input type="checkbox"/> Hospitalization			
12. INJURY DESCRIPTION (CHECK ALL THAT APPLY) <input type="checkbox"/> Abrasion <input type="checkbox"/> Frostbite <input type="checkbox"/> Bite <input type="checkbox"/> Heat related Illness <input type="checkbox"/> Burn <input type="checkbox"/> Puncture <input type="checkbox"/> Bruise/ Contusion <input type="checkbox"/> Scratches <input type="checkbox"/> Complaint of Pain <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Cut/ Laceration <input type="checkbox"/> Swelling <input type="checkbox"/> Dislocation <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Fracture/Break	13. INJURED BODY PARTS (CHECK ALL THAT APPLY) <input type="checkbox"/> Head <input type="checkbox"/> Shoulder R/L <input type="checkbox"/> Lower Back <input type="checkbox"/> Knee R/L <input type="checkbox"/> Face <input type="checkbox"/> Upper Arm R/L <input type="checkbox"/> Abdomen <input type="checkbox"/> Calf R/L <input type="checkbox"/> Eye R/L <input type="checkbox"/> Elbow R/L <input type="checkbox"/> Waist <input type="checkbox"/> Shin R/L <input type="checkbox"/> Ear R/L <input type="checkbox"/> Forearm R/L <input type="checkbox"/> Hip R/L <input type="checkbox"/> Ankle R/L <input type="checkbox"/> Nose <input type="checkbox"/> Wrist R/L <input type="checkbox"/> Genitals <input type="checkbox"/> Foot R/L <input type="checkbox"/> Mouth <input type="checkbox"/> Hand R/L <input type="checkbox"/> Buttock R/L <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Teeth <input type="checkbox"/> Chest <input type="checkbox"/> Thigh R/L <input type="checkbox"/> Neck <input type="checkbox"/> Upper Back	(CIRCLE R or L BELOW) FINGERS TOES <input type="checkbox"/> Thumb R/L <input type="checkbox"/> Big R/L <input type="checkbox"/> Index R/L <input type="checkbox"/> 2 nd R/L <input type="checkbox"/> Middle R/L <input type="checkbox"/> 3 rd R/L <input type="checkbox"/> Ring R/L <input type="checkbox"/> 4 th R/L <input type="checkbox"/> Little R/L <input type="checkbox"/> Little R/L	
14. MEDICATION ERROR CATEGORY (SELECT ONE) <input type="checkbox"/> Failure to Administer Reason _____ <input type="checkbox"/> No Physician Order <input type="checkbox"/> Wrong Dose	<input type="checkbox"/> Wrong Form <input type="checkbox"/> Wrong Medication <input type="checkbox"/> Wrong Person <input type="checkbox"/> Wrong Route <input type="checkbox"/> Wrong Time	15. MEDICATION ERROR SEVERITY RATING (SELECT ONE) <input type="checkbox"/> Minimal: No treatment or intervention other than monitoring or observation <input type="checkbox"/> Moderate: Treatment and/or interventions in addition to monitoring or observation <input type="checkbox"/> Serious: Life threatening and/or permanent adverse consequences	

(Check one) **Event** or **Discovery Date & Time:** _____ : _____ **AM/PM** **Consumer ID:** _____

16. NOTIFIED: Persons /Agencies	Name of Person Contacted	Date	Time
<input type="checkbox"/> DMH Regional Center			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Family or Guardian			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Physician			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Law Enforcement			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> DSS Children's Division			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> DHSS			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> 911			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Coroner or Medical Examiner			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Other			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM

17. **EVENT DESCRIPTION:** Describe what happened and interventions used by staff:

Attach additional pages if necessary

18. **IMMEDIATE ACTION TAKEN BY AGENCY AND ACTION STEPS TO PREVENT REOCCURENCE (To be completed by agency management)**

19. Signature-Reporter	Phone Number ()	Agency Name	Date ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
20. Signature-Agency Management/Supervisor			Date ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
21. Signature-Service Coordinator			Date ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
22. Signature-Other DMH Staff			Date ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM

23. **ACTION/ COMMENTS (To be completed by DMH)**

Suspicion or Allegation of Abuse, Neglect or Misuse of Consumer Funds/Property? YES NO If yes to either question, must be entered into EMT within 1 working day

If a death occurred: Suspected Manner of Death ACCIDENT HOMICIDE NATURAL SUICIDE UNDETERMINED

Was consumer seen by physician with prior 24 hours? YES NO

Is an Autopsy being performed? YES NO If Yes, list Coroner/Medical Examiner: _____

Check any of the following contacts that are required: DMH Facility Head Parent/Guardian Local Law Enforcement DHSS DSS Highway Patrol Coroner or Medical Examiner STAT Team

Please attach documentation that all required contacts have been made (if contact information is not already included on this form) prior to presenting the form for data entry