ADVERSE EVENT REPORT IMMEDIATE NOTIFICATION

Please send to Ohana via FTP

Member	
Member Plan ID:	Member First Name:
Medicaid ID number:	Member Last Name:
Member Phone Number:	Date of Birth:
Primary Contact:	Home Address:
Relationship to Member:	Contact Phone Number:

Treating Case Management Provider	
Provider ID:	
Case Management Agency:	
Phone Number:	Fax Number:
Case Manager Name:	Case Manager Phone Number:
Date of Last face-to-face contact prior to adverse event:	
Case Management Ratio (# of members per this member's case manager):	

Diagnosis		
Primary	Diagnosis Code:	Description:
Secondary	Diagnosis Code:	Description:
Current LOCUS/Denver Score:		
Co-Occurring Substance Abuse Disorder: ☐ ETOH ☐ Drugs ☐ Unknown ☐ None		
Medical / Developmental Conditions:		

Adverse Event Details	
Date / Time of Event:	Date Case Manager Notified:
Location: ☐ Hospital ☐ Treatment Program ☐ Member Residence ☐ Other _____	

Adverse Event Detailed Description *(Please indicate who, what, how & why. Be comprehensive & concise. List any safety issues & provide status update on member. What are the immediate plans for member? If not completing electronically, please add a second page if needed)*

Adverse Event Type (check applicable event)

Category A	Category B
☐ Suicide of member	☐ Attempted homicide of, or by, a member
☐ Homicide of a member	☐ Attempted suicide
☐ Homicide by a member	☐ Elopement from a crisis shelter, residential facility or group home that posed significant personal/public safety risk
☐ Death of a member unanticipated, that may have resulted from lack of treatment, or otherwise not clearly and primarily related to the natural course of the consumer's medical illness	☐ Physical assault by a member resulting in permanent loss of limb or function thereof
☐ Serious member injury resulting in permanent loss of limb or function, or risk thereof	☐ Physical assault by a member
☐ Medication Error – any member death, paralysis, coma or permanent loss of function associated with a provider medication error	☐ Death of a member
☐ Suspected sexual abuse/neglect of a member	☐ Loss of housing
☐ Other _____	☐ Altercation with Law Enforcement including incarceration
	☐ Other _____

Current medications *(psychiatric, medical and over the counter):*				Please attach additional page if necessary
Name	Dose	Frequency	Route	Compliance History

Providers *(please list all providers)*				
Type:	Name of Provider	Contact #	Date Last Seen	Provider Notified
PCP:				
Psychiatrist / APRN:				
Therapist:				
Other:				
Other:				

Hospitalizations /ER Visits *(within the last 6 months)*					
Facility	Location	Date Admitted	Date Discharged	Reason for Admission	Medical or BH

Housing / Living Situation

☐ Independent Living ☐ Group Home/TLP ☐ LCRS ☐ Licensed Specialized Residential ☐ Homeless
☐ Homeless Shelter ☐ Care Home ☐ Foster Home ☐ Nursing Home ☐ Hospital ☐ Other _____

Agency Completing Adverse Event Form	
Program Name:	Reported by (name & title):
Phone number:	Fax number:
Date Form completed:	

Additional Required Documents (to be submitted with this form)	
☐ Psychiatric Evaluation (most recent)	☐ Autopsy Report (if / when available)
☐ Master Recovery Plan (most recent)	☐ Police Report (if available)
☐ Crisis Plan (most recent)	☐ Case Manager Progress Notes (30 days prior to AE)