



ADVERSE EVENT REPORT IMMEDIATE NOTIFICATION

Please send to Ohana via FTP

Member	
	Today's Date:
Ohana Member ID:	Member Name:
Medicaid ID number:	Date of Birth:
Member Phone Number:	Home Address:
Primary Contact and relationship:	Primary Contact's 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 in-person contact prior to adverse event:	
Case Management Ratio (# of members per this member's case manager):	
Diagnosis	
Primary	ICD-10 Diagnosis Code: Description:
Secondary	ICD-10 Diagnosis Code: Description:
Current LOCUS:	
Co-Occurring Substance Use Disorder: <input type="checkbox"/> ETOH <input type="checkbox"/> Drugs <input type="checkbox"/> Unknown <input type="checkbox"/> None	
Medical / Developmental Conditions:	
Adverse Event Details	
Date / Time of Event:	Date Case Manager Notified:
Location: <input type="checkbox"/> Hospital <input type="checkbox"/> Treatment Program <input type="checkbox"/> Member Residence <input type="checkbox"/> Other _____	
Adverse Event Detailed Description <i>(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)</i>	
Adverse Event Type (check applicable event)	
Category A <input type="checkbox"/> Suicide of member <input type="checkbox"/> Homicide of a member <input type="checkbox"/> Homicide by a member <input type="checkbox"/> 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 <input type="checkbox"/> Injury requiring medical attention <input type="checkbox"/> Medication Error – any member death, paralysis, coma or permanent loss of function associated with a provider medication error <input type="checkbox"/> Suspected sexual abuse/neglect of a member <input type="checkbox"/> Other _____	Category B <input type="checkbox"/> Attempted homicide of, or by, a member <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Elopement from a crisis shelter, residential facility or group home that posed significant personal/public safety risk <input type="checkbox"/> Involvement with APS <input type="checkbox"/> Physical assault of, or by, a member <input type="checkbox"/> Death of a member <input type="checkbox"/> Loss of housing <input type="checkbox"/> Altercation with Law Enforcement including incarceration <input type="checkbox"/> 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)

<input type="checkbox"/> Behavioral Health Assessment (most recent)	<input type="checkbox"/> Autopsy Report (if / when available)
<input type="checkbox"/> Individualized Treatment Plan (most recent)	<input type="checkbox"/> Police Report (if available)
<input type="checkbox"/> Crisis Plan (most recent)	<input type="checkbox"/> Case Manager Progress Notes (30 days prior to AE)