



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	
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"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Unknown <input type="checkbox"/> None		
Medical / Developmental Conditions:		

Adverse Event Details	
Date / Time of Event:	Date Adverse Event Reported to 'Ohana:
Location: <input type="checkbox"/> Hospital <input type="checkbox"/> Treatment Program <input type="checkbox"/> Member Residence <input type="checkbox"/> Other _____	

Adverse Event Detailed Description (Please indicate who, what, how, and why. Be comprehensive and concise. List any safety issues and 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
<input type="checkbox"/> Member-Experienced Adverse Event
<input type="checkbox"/> Member-Perpetrated Adverse Event

Adverse Event Type:
<input type="checkbox"/> 01 = Adverse Drug Event
<input type="checkbox"/> 02 = Treatment Related
<input type="checkbox"/> 03 = Healthcare-Acquired Condition
<input type="checkbox"/> 04 = Other Provider-Preventable Condition
<input type="checkbox"/> 05 = Assault
<input type="checkbox"/> 06 = Exploitation
<input type="checkbox"/> 07 = Restraints / Seclusion
<input type="checkbox"/> 08 = Neglect
<input type="checkbox"/> 09 = Abuse
<input type="checkbox"/> 10 = Suicide Attempt
<input type="checkbox"/> 11 = Suicide

- 12 = Fall / Injury
- 13 = Elopement / Missing
- 14= Loss of Housing
- 15 = Arrested
- 16= MH-1
- 17 = Incarcerated
- 18= Involved with Adult Protective Services
- 19 = Other Event Related to Resident Care
- 20 = Other Event Related to Medical Care
- 21 = Other Event Related to Legal System
- 22 = Accidental Overdose

Location of Adverse Event: _____

Community Integration Services (CIS) Classification:

Yes No

Level and Type of Harm:

- 1 = No Harm
- 2 = Temporary Harm
- 3 = Permanent Harm
- 4 = Death

Did a similar Adverse Event occur in the same setting in the year prior to the Adverse Event: Yes No

Did a similar Adverse Event occur to the same member in the year prior to the Adverse Event? Yes No

Was the Adverse Event shared to member's QI PCP?: Yes No

- If yes, please enter date shared with member's QI PCP: _____
- If no, please explain why:

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

- AMHD EARCH Home**
 Boarding Home
 Care Home
 Church Housing
 Clean and Sober Home
 Foster Home
 Homeless in Shelter
 Homeless Unsheltered
 Lives Alone
 Lives with Caregiver
 Lives with Family Member
 Couch Surfing
 Lives with Partner
 Lives in Mental Health Group Home
 Mental Health Residential Treatment
 Nursing Facility
 Specialized Shelter
 Substance Use Residential Treatment
 Rents a Room

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 Adverse Event)