BEHAVIORAL care NETWORK

Critical Incident Follow Up Form

Fax this form to BCN Quality Improvement Coordinator
Fax: 503-585-4989

Send form no later than 15 days after the end of the quarter during which the review was completed.

Note: If Member was receiving care from multiple BCN agencies, please notify the other agencies of the incident and complete form in an interagency review prior to submission to BCN.

Date of Report: _____ Date of Agency QMC Review: _____

Member Medicaid ID#: _____

Agency Name: _____

Person Submitting Report: _____

Incident Date: _____ Incident Location: _____

Diagnoses at Most Recent Contact (list all, including medical): _____

Treatment History

Length of Treatment Time at Agency: _____ Date of Last Treatment Contact: _____

Substance Abuse

History: ☐ None ☐ Previous ☐ Current (at time of incident)

Treatment: ☐ None ☐ Previous ☐ Current (at time of incident)

Psychotropic Medication

Prescribed at time of incident? ☐ Yes ☐ No

Taking as prescribed? ☐ Yes ☐ No

Recent changes in meds or use? ☐ Yes ☐ No

Services

Service	Frequency of Services (x times a week/month)	Member Attendance (H/M/L)	Member Engagement (H/M/L)
Med. Management			
Case Management			
Individual Counseling			
Family Therapy			
Group Counseling			
Peer Support			

Other: _____			

Additional Information (if available):

Other Agency Involvement

☐ Child Welfare ☐ Self Sufficiency ☐ Corrections ☐ Other: _____

Housing Status

☐ Lives Alone ☐ Lives With Others ☐ Group Home ☐ Foster Home
☐ Homeless ☐ Other: _____

Family Relationships

☐ Close Contact ☐ Some Contact ☐ Little/No Contact ☐ Recent Family Crisis

This section to completed only if this was a completed or attempted suicide

Ideation/Attempts

☐ None ☐ Ideation Only ☐ 1-2 Attempts ☐ 3-4 Attempts ☐ 5+ Attempts

Timeframe

☐ Prior Week ☐ Prior Month ☐ 1-2 Years ago ☐ 3-4 Years ago ☐ 5+ Years Ago

Contact with Provider by Member in week prior to the incident (check all that apply):

☐ None
☐ Crisis Call Line
☐ Phone contact w/worker/therapist
☐ Phone contact with other agency staff
☐ Presented at PCC or other crisis service
☐ Presented at ER
☐ In-person contact within 1 week
☐ In-person contact within 1 day
☐ Emergency (EMT) or mobile crisis intervention
☐ Call to agency by concerned person(s)
☐ Scheduled appointment but no show
☐ Agency attempted contact but no success

Describe any pattern in this person's suicide attempts (methods, triggers, timing, etc.):

_____

Describe use of CAMS with this individual: _____

This section is to be completed for all Critical Incidents following agency QMC Review

Describe factors that contributed to the incident: _____

Describe any recommended changes in agency practice as a result of the critical incident: _____

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Describe any broader system recommended changes including BCN, providers, community, etc.: _____