The SIROF form must be typed. Handwritten reports will be returned to programs for a typed [report.](https://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5079.pdf) [All fields are required](https://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5079.pdf) and must be completed unless otherwise noted. Incomplete Forms May Be Returned.

# For questions or consultation regarding SIROF’s or reporting incidents, contact BHS QA at 619-584-3022 or email QI Matters: qimatters.hhsa@sdcounty.ca.gov.

See SIROF FAQ/Tip Sheet posted on the Optum site additional details for completing the SIROF Form and reporting to BHS QA. Located under “Forms” tab on under the MHP and DMC Optum pages.

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| 1. **PROGRAM REPORTING SIR**

*Provide details about program reporting SIR/SIROF, including staff completing/submitting the SIR form.*  |
| Agency/Legal Entity Name |       |
| Program Name |       |
| Program Manager Name  |       |
| Program Manager Email |       |
| Program Manager Phone Number |       |
| Program Type (MH) | Click to view/select optionsIf “other” selected:       |
| Program Type (SUD) | Click to view/select options If “other” selected:       |
| Staff Name Reporting SIROF |       |
| Date Staff Reporting |       |
| Contracting Officer Representative (COR) |       |

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| 1. **INCIDENT INFORMATION**

*Provide details about the incident: date of incident, SIROF submission dates; RCA requirements and date*  |
| Date of Incident |       |
| Was SIROF submitted to QA within 30 days of the reported incident?  | [ ]  Yes [ ]  No |
| If no, why?  |       |
| Is RCA required?  | [ ]  Yes [ ]  No |
| If yes, date RCA completed |       |

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| 1. **CLIENT INFORMATION**

*Provide details about the client involved in the incident: client name; client record number for CCBH or SanWITS; custody info*  |
| Client Name |       |
| CCBH Number |       |
| SanWITS Number |       |
| Was the person in custody within the last 30 days?  | [ ]  Yes [ ]  No |

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| 1. **OVERDOSE INFORMATION**

*Complete the following for serious incidents related to an overdose**If incident not related to overdose, indicate here:* ​ [ ]  ​ N/A |
| 1. Substance involved in the overdose
 | Click to view/select optionsOther:       |
| 1. If Opioid was involved, was the client receiving Mediation Assisted Treatment (MAT) services
 |  [ ]  Yes [ ]  No |
| 1. If yes, was the client referred to MAT?
 |  [ ]  Yes [ ]  NoReferred to:       |
| 1. If client was not referred to MAT or declined a referral to MAT, please explain:
 |       |
| 1. Was Naloxone/Narcan administered?
 |  [ ]  Yes [ ]  NoBy whom:       |
| 1. Was fentanyl specific testing included in all client urine drug screens?
 |  [ ]  Yes [ ]  NoDate of most recent fentanyl specific test:       |
| 1. If yes, result of most recent fentanyl specific test
 | Click to review/select options |
| 1. Was the client given health education about Naloxone/Narcan for overdose prevention as part of treatment prior to the incident (i.e., intake)?
 | [ ]  Yes [ ]  No |
| 1. Was Naloxone/Narcan kit prescribed or given to the patient for overdose prevention prior to the incident (not including any staff administration of naloxone)?
 | [ ]  Yes [ ]  No |

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| 1. **SERIOUS INCIDENT OF SUMMARY FINDINGS RESULTS AND RECOMMENDATIONS**

*Describe the results of your investigation and recommendations as a result of the incident.* *NOTE: Section not required if RCA was complete; indicate N/A* [ ]  *for this section and complete section 6 below.*  |
| 1. Describe the results of your investigation and analysis of the serious incidence
 |
|       |
| 1. Describe recommendations or planned improvements including a summary of quality/system improvements as a result of the analyst of the serious incident.
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|       |

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| 1. **ROOT CAUSE ANALYSIS (RCA)**

*If required, provide details for RCA if an RCA has been completed: if root cause was identified, findings and action items.* *If RCA has not been completed, indicate N/A* [ ]  |
| 1. Was a root cause identified?
 | [ ]  Yes [ ]  No |
| 1. RCA Summary of Findings
 |
|       |
| 1. RCA Summary of Action Items
 |
|       |

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| 1. **PROGRAM MANAGER ATTESTATION**

*This section shall only be completed by Program Manager or Designee Only* |
| [ ]  By checking this box, I       attest that on this date       I have read and agree with the information included in this Serious Incident Report.  |