This form **must** be typed. Handwritten reports will be returned to programs. [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 immediate resubmission. For questions or consultation regarding CIR’s or reporting incidents, please contact BHS QA at QI Matters: [QiMatters.hhsa@sdcounty.ca.gov](mailto:QiMatters.hhsa@sdcounty.ca.gov).

See CIR FAQ/Tip Sheet posted on the Optum site for additional details for completing the CIR Form and reporting to BHS QA. Located in the Incident Reporting Tab of the SMH &DMC-ODS Plans Optum Page.

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| 1. **PROGRAM REPORTING CIR**   *Provide details about program reporting CIR, including staff completing/submitting the CIR form.*   * *Critical Incident: Fax/email within 24 hours* | |
| Program Type | Click to view/select options |
| Agency/Legal Entity Name |  |
| Program Name |  |
| Program Manager Name |  |
| Program Manager Email |  |
| Program Manager Phone Number |  |
| Name of Staff Reporting |  |
| Date Staff Reporting |  |
| Contracting Officer Representative (COR) |  |
| Contract # *(if known or available)* |  |

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| 1. **INCIDENT INFORMATION**   *Provide details about the incident: date/time, location of incident; staff involved in the incident; date incident reported to the program; type of incident (use drop down menu); if reported to media, include relevant material or links to news stories;* | |
| Date of Incident |  |
| Time of Incident | Unknown |
| Location of Incident | Click to view/select options  If “other” selected: |
| Staff Involved with Incident | Yes  No *(If yes, include staff name in Section 3.)* |
| Date Program Aware of Incident |  |
| Critical Incident Type | Click to view/select options |
| If “adverse media/social media incident”, provide links for incident. |  |
| Client category (*Required for SMH or DMC-ODS treatment program type only)* | Click to view/select options  *Note:*   * *OOC Clients – county of residence notification required; indicate in section 4* * *OOC & Non-BHS clients – skip section 6 for client info* |

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| 1. **DESCRIBE THE CRITICAL INCIDENT**   *Describe in detail the critical incident, addressing all items below. If OOC Client or Non-BHS Client, do not include PHI.* |
| 1. People involved, precipitating factors, and details of incident |
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| 1. Indicate if client was admitted for medical or psychiatric care as a result of the incident |
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| 1. Describe any physical, medical, or other concerns as a result of the incident |
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| 1. **NOTIFICATIONS**   *Indicate other departments/parties notified regarding the incident with date/time of notification.*  *If notification is not required for the client, indicate here:*  N/A | | | |
| **a)** | Entity: Click to view/select options  If “other” selected: | Date:  Time: | Notification Type: Click to view/select options |
| **b)** | Entity: Click to view/select options  If “other” selected: | Date:  Time: | Notification Type: Click to view/select options |
| **c)** | Entity: Click to view/select options  If “other” selected: | Date:  Time: | Notification Type: Click to view/select options |
| **d)** | Entity: Click to view/select options  If “other” selected: | Date:  Time: | Notification Type: Click to view/select options |
| **e)** | Entity: Click to view/select options  If “other” selected: | Date:  Time: | Notification Type: Click to view/select options |
| **f)** | Entity: Click to view/select options  If “other” selected: | Date:  Time: | Notification Type: Click to view/select options |

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| 1. **NOTIFICATIONS (SUD RESIDENTIAL ONLY)**   *Report to DHCS CIRs related to death, injury that requires medical treatment, communicable diseases, poisonings, natural disaster and/or fires or explosions on premises. If notification is not required, indicate here:*  N/A | |
| Death/Injury that required medical treatment, communicable diseases, poisonings, natural disaster and/or fires or explosions on the premise? | Yes  No |
| Telephonic Report (916) 322-2911 (within 24 hours) | Date:  Time: |
| If Applicable, Written (Within 7 days of the Event)  [DHCS 5079 titled “Unusual Incident/Injury/Death Report”](https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-5079-Unusual-Incident-Report.pdf) | Yes  No |
| If Applicable, death report submitted via fax to the DHCS Complaints and Counselor Certification Division at (916) 445-5084 or by email to [DHCSLCBcomp@DHCS.ca.gov](mailto:DHCSLCBcomp@DHCS.ca.gov) | Date:  Time: |

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| 1. **CLIENT INFORMATION**   *Provide details about client involved in the incident: name & DOB; DSM dx; electronic health record number; last date of service, if applicable. Note: If OOC Client or Non-BHS Client, this section is not required.* | |
| Client Name |  |
| DOB |  |
| DSM-5 Diagnosis, if applicable |  |
| EHR Number, if applicable |  |
| Date of Last Service, if applicable |  |
| Is the client involved with or connected to other departments, entities, or behavioral health services? | Yes  No  *If yes, Indicate any other services the client is receiving; example: Outpatient, FSP/ACT, WRAP, SBCM, medication management, day treatment, residential, recovery services, etc.* |

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| 1. **PROGRAM MANAGER ATTESTATION**   *This section shall only be completed by Program Manager or Designee Only; select only one option.* |
| I am the Program Manager and am attesting that the information provided is accurate.  I am submitting on behalf of the Program Manager and am attesting that the information provided is accurate and has been reviewed with the Program Manager. |