![Maryland Department of Health logo]

BHA COMAR 10.63 Critical Incident Report Form

Behavioral Health Administration incident report mandated under COMAR 10.63

INSTRUCTIONS

All Behavioral Health Providers licensed under COMAR 10.63 are required to complete and submit this form to the Behavioral Health Administration (BHA) at **critical.incident@maryland.gov** within five (5) calendar days of a reportable incident. A copy of the report will be forwarded to the appropriate local designated authorities (LDA).

This form must be completed in full for all critical incidents (as defined in COMAR 10.63.01.02 (19)) and listed below. Additionally the form is required for overdoses, whether resulting in death or not.   Special instructions exist for the following:

UNEXPECTED EVACUATION OF A BUILDING: In the event of unexpected evacuation of a building under circumstances that threaten the life, health or safety of participants, complete only Sections I, II, V, VI of this form.

 RESIDENTIAL REHABILITATION PROGRAMS, RESIDENTIAL CRISIS PROGRAMS, AND GROUP HOMES: If the critical incident being reported is a participant death, complete both this form and **ADDITIONALLY**, complete the BHA Report of Death Form (DHMH Form #4364) which can be found at [BHA Death Report]

SECTION I: INCIDENT INFORMATION

Provider Internal Incident Tracking # (Optional)

[text field]

Enter organization's internal incident number if desired.

Critical Incident Type

SECTION I: CRITICAL INCIDENT TYPE (Check ALL that apply)

☐ Death of a program participant (RRP, Crisis and Group Homes must also complete Death Report)

☐ Life-threatening injury to a program participant (report serious injury and near-misses)

☐ Non-consensual sexual activity, as prohibited in COMAR 10.01.18.

☐ Sexual activity between a staff member and a program participant (May be separately reportable under COMAR 10.01.18)

☐ Unexpected evacuation of a building under circumstances that threaten the life, health or safety of

participants;

☐ Diversion of medication from the stock of a program providing opioid treatment services

☐ Injury related to an opioid medication dispensed by a program providing opioid treatment services.

☐ Overdose resulting in death

☐ Overdose NOT resulting in death

☐ Unexplained disappearance of an individual with potential life-threatening health condition

☐ Reportable Disease or Condition as listed in COMAR 10.06.01.03

☐ Other (Specify below)

SECTION II: INCIDENT DETAIL

Name of Person completing report

Title	First	Last

Dr/Mr/Ms Name   *First Name*   *Last Name*

Phone of person completing report

Email of person completing report

Date Incident occurred   **Date Program discovered incident**   **Date reported to BHA**

If date unknown, leave blank

Description of Incident (who, what, where, when)

Was 911 called?
○ Yes ○ No ○ Unknown

Was medical attention provided to anyone?
○ Yes ○ No ○ Unknown

Was anyone transported to the hospital
○ Yes ○ No ○ Unknown

Was a police report filed?

○ Yes ○ No ○ Unknown

Was an arrest made?
○ Yes ○ No ○ Unknown

Was there a witness to the incident?
○ Yes ○ No ○ Unknown
If yes, be sure to list in Section IV

Was Naloxone administered?
○ Yes ○ No ○ Unknown

SECTION III: PROGRAM INFORMATION
Please enter the address where the incident occurred regardless of where the individual is served

Name of Agency

Name and or Type of Program involved in incident (if different from Agency Name)

Street Address where incident occurred

City	State	Zip	County
	MD		

Name of Agency Director/CEO	Director/CEO's Phone

Director/CEO's Email

SECTION IV: INDIVIDUALS INVOLVED IN INCIDENT (Add as many as necessary)

A. Staff involved in Incident
Click +Add Item to add addtiional Staff

Staff Name	Credential/Position	Contact Phone	Email

B. Program Participants Involved directly in Incident
Click +Add Item to add additional Participants

Item 1

Participant First Name	Participant Last Name	Date of Birth

Involvement in Incident
⊙ Directly involved in incident ○ Witness to Incident

Contact Information (phone or email)

Gender
○ Male ○ Female
⊙ [_____]

Date of this admission

Agency Medical Chart ID

Most recent contact with who on agency staff?

Date of this contact

This is the most recent date in contact with agency

Does this participant use substances, receives Medications for Opioid Use Disorder (MOUD) or substances are suspected in this incident?
○ Yes ○ No ⊙ Unknown

Additional relevant Information on Participant (not already presented)

C. Witnesses to the Incident (not directly involved)
Click +Add Item to enter addtional individuals

First and Last Name	Involved?	Contact Information

SECTION V: Listing of Individuals providing ongoing services to those involved in Incident
Click +Add Item to add additional treatment staff

Enter all key providers for Individuals involved in Incident

Item 1

Name   **Credential**

Title   First   Last

Untitled

⊙ Works for Reporting Agency ○ Does NOT work for Reporting Agency

Role   **Phone**

Involved Participants treated by this individual

Additional Comments

Section VI: Quality Management

Lessons learned and steps to be taken to improve service and reduce risk of repeat

Include corrective actions, p&p changes, training, etc.

Thank you for completing this form. You may now click submit and it will transmit to the Behavioral Health Administration and the Local Designated Authority for follow up

LDA (LBHA/CSA/LAA) OFFICE USE ONLY

Untitled

☐ Form Received ☐ Follow up Initiated ☐ Incident Investigation complete

Comments

BEHAVIORAL HEALTH ADMIN OFFICE USE ONLY

To be Followed by
○ #1 ○ #2 ○ #3 ○ #4
⊙ [   ]

Sent to

BHA Follow Up

BHA Case Status
⊙ Open ○ Pending Feedback ○ Completed