

Critical Incident Report for Home and Community Based Settings

Contact VSHP CHOICES verbally within 24 hours of notification of the incident at 1-888-747-8955 and fax this form with 48 hours to (615) 565-1923

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Blue Care Number			Today's Date and Time			
Member's Name			Incident Discovery Date and Time			
Member's Date of Birth			Incident Date and Time			
Member's Home Address			Location of Incident			
Member's City, State ZIP						
Member's Phone Number 1			Are Back-up Services Required?			
Member's Phone Number 2			Provider involved in Incident			
Critical Incident Type						
	Individual filling out this form	P	erson Involved in the Incident	Person Invo	lved in the Incident	
Name						
Company						
Relationship						
Phone Number						
	Person Involved in the Incident	P	erson Involved in the Incident	Person Invo	lved in the Incident	
Name						
Company						
Relationship						
Phone Number						
Emergency Medical Services (EMS) Contacted?	EMS Name		Phone		Date	
Adult Protective Services Contacted (APS)?	APS Name Phone Date and If the incident involves abuse, neglect or exploitation - report the incident to APS within 24 hours of discovery of the incident. Time					
Police Department Contacted?	Police Dept Name		Phone		Date	
Officer Name	Police Report Number					
Other Service	Contact Name		Phone #	Date		
Other Service	Contact Name		Phone #	Date		
Other Service	Contact Name		Phone #	Date		



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Where is the member currently? If this incident is due to a Medication Error, please provide the following information. Name of Location Name of Location Address 1 Prescribed Trequency Address 2 City, State 2IP Prescribed Route Prescribe			, ,						
Name of Location Address 1 Address 2 City, State 2IP Temporary Phone number Write a clear narrative of what happened. State only the facts of the event. (Who, What, Where, When and How). Describe what led up to the incident. Document the Source Name for Third Party Accounts. Explain the member's condition due to the incident. Document the corrective action(s) taken including dates and times. (investigation, actions and reporting) Include the actions taken to ensure our member's safety. Reassignment Name of Caregiver Removed: Prescribed Dosage Prescribed Prequency Prescribed Frequency Incident Dosage Prescribed Route Prescribed Frequency Incident Dosage Prescribed Prequency Incident Prescribed Route Incident Prequency Incident Prequency Incident Prescribed Route Incident Prequency Incident Prescribed Route Incident Ro	Where is the member currently?		If this incident is due to a Medication Error, please provide the following information.						
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	Reassignment		Date and Time the Caregi	ver was Removed:					
		Name of Caregiver Assigned:	Date and Time the New Co	aregiver was Assigned:					