

**ADULT MENTAL HEALTH DIVISION**  
**Consumer Sentinel Event Report**  
*Immediate Notification*

**PURPOSE:**

To promote the safety of Adult Mental Health Division (AMHD) registered consumers and improve the system of care and treatment, uniform processes shall be established and implemented to identify report, analyze and investigate consumer sentinel events.

*Complete the blanks as thoroughly as possible. Use an X mark in the boxes as appropriate.*

**1. Consumer's Name:** (Last): \_\_\_\_\_ (First): \_\_\_\_\_

**2. Sex:** Male  Female

**3. Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
dd mm yyyy

**4. AMHD Reference Number:** \_\_\_\_\_

**5. Date of Sentinel Event:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**6. Sentinel Event Brief Description:** \_\_\_\_\_

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**Event Codes:** *Choose only one event code. If more than one code applies contact Performance Improvement at 808.453.6936*

**Category A**

- a.  Suicide of a consumer.
- b.  Homicide of a consumer.
- c.  Homicide by a consumer.
- d.  Medication Error – any consumer death, paralysis, coma, or a permanent loss of function associated with a provider medication error.
- e.  Serious consumer injury resulting in permanent loss of limb or function or risk thereof.
- f.  Suspected abuse/sexual/neglect of a consumer.



10. Axis I Primary psychiatric diagnosis:(use DSM IV codes): \_\_\_\_\_

11. Co-occurring disorder:
- |  |                                     |
|--|-------------------------------------|
| a. <input type="checkbox"/> ETOH           | d. <input type="checkbox"/> none    |
| b. <input type="checkbox"/> drugs          | e. <input type="checkbox"/> unknown |
| c. <input type="checkbox"/> ETOH and drugs |                                     |

12. Axis II (Use DSM IV codes): \_\_\_\_\_

13. Mental Retardation:
- |  |  |
|--|--|
| a. <input type="checkbox"/> mild (including borderline intellectual functioning) | c. <input type="checkbox"/> moderate       |
| b. <input type="checkbox"/> mild to moderate                                     | d. <input type="checkbox"/> not applicable |

14. Number of medications taken daily: (Add total psychiatric and non-psychiatric including over-the counter and herbal/vitamins):

- |                                 |                                       |
|---------------------------------|---------------------------------------|
| a. <input type="checkbox"/> 0   | d. <input type="checkbox"/> 6-8       |
| b. <input type="checkbox"/> 1-2 | e. <input type="checkbox"/> 8 or more |
| c. <input type="checkbox"/> 3-5 | f. <input type="checkbox"/> unknown   |

15. Current Medications (List names and doses): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. Level of Case Management:

- |   |   |
|---|---|
| a. <input type="checkbox"/> Care Coordination         | f. <input type="checkbox"/> Assertive Community Treatment |
| b. <input type="checkbox"/> Crisis Support Management | g. <input type="checkbox"/> Community Care Services (CCS) |
| c. <input type="checkbox"/> Crisis Mobile Outreach    | h. <input type="checkbox"/> Developmental Disabled Branch |
| d. <input type="checkbox"/> Targeted Case Management  | i. <input type="checkbox"/> Inpatient Hospital Services   |
| e. <input type="checkbox"/> Intensive Case Management | j. <input type="checkbox"/> Homeless Outreach             |
|   | k. <input type="checkbox"/> None                          |

17. Case management agency: \_\_\_\_\_

18. Case management ratio(# of consumers per this consumer's case manager) \_\_\_\_\_

19. Date of last face-to-face contact prior to event: \_\_\_\_\_

20. Psychiatrist:
- |   |  |
|---|--|
| a. <input type="checkbox"/> POS                         | d. <input type="checkbox"/> HSH                  |
| b. <input type="checkbox"/> CMHC                        | e. <input type="checkbox"/> Private psychiatrist |
| c. <input type="checkbox"/> Client refuses Psychiatrist | f. <input type="checkbox"/> VAMHC                |



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**Please complete the following information about your agency:**

**31. Agency completing the form:** \_\_\_\_\_

**32. Program name:** \_\_\_\_\_

**33. Reported by (Name, Title):** \_\_\_\_\_

**34. Phone number:** \_\_\_\_\_

**35. Date form completed:**     /    /      
                                  *dd mm yyyy*

	Signature	Date
Reported by	_____	___/___/___
AMHD Quality Improvement Administrator	_____	___/___/___
AMHD Performance Improvement	_____	___/___/___
Coordinator	_____	___/___/___
AMHD Medical Director	_____	___/___/___

*\* Fax this form to 1 (808) 453-6995*