**SBHO INCIDENT REPORT FORM**

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| **Community Mental Health Centers must complete this form when reporting incidents related to persons with mental illness who have an open case with the BHO and who are the alleged victims or perpetrators of the events listed below. Violent Act, per RCW, (*Act that results in charges or pending charged*).** | | |
| **SBHO AND INCIDENT INFORMATION** | | |
| Today’s Date Click or tap to enter a date.  Date BHO was notified: Click or tap to enter a date.  Reporting BHO: Choose an item. | | Date of Incident: Click or tap to enter a date.  Time of incident: 00:00  Location of incident: |
| Name of Contacting Person: | Type of Incident: Choose an item. | |
| Brief description of the incident:  Click or tap here to enter text.  Names and ages of all Enrollees involved in the incident:  Click or tap here to enter text.  Names and titles of facility personnel or other staff involved in the incident:  Click or tap here to enter text.  Names and relationship, if known, of other persons involved in the incident:  Click or tap here to enter text.  The nature and degree of involvement for all other persons:  Click or tap here to enter text.  The Enrollee's whereabouts at the time of the report if known (i.e., home, jail, hospital, unknown, etc.) or actions taken by the Contractor to locate the Enrollee:  Click or tap here to enter text.  Actions taken by the Contractor to minimize harm resulting from the incident:  Click or tap here to enter text.  Any legally required notifications made by the Contractor: **YES  NO**  *(If yes, please describe)*  Click or tap here to enter text. | | |
| |  | | --- | | **OTHER AGENCY/FACILITIES NOTIFIED/INVOLVED** | | Other Agencies notified:  Other Agencies/Facilities involved: | | | |
| **CLIENT INFORMATION** | | |
| Last Name: | | First Name: |
| **INVESTIGATION INFORMATION (If required by Mental Health Division)** | | |
| Date of Investigation: Click or tap to enter a date.  Email:  Telephone: | | Name of Investigator (facility/agency staff):    Fax: |
| **FOLLOW-UP/CORRECTIVE ACTION INFORMATION (If required by MHD)** | | |
| Date of Follow-up: Click or tap to enter a date. | | Follow-up action taken: |
| **Case closed**  Date case closed:Click or tap to enter a date. | | **Referral required**  Agency of Referral:  Date of referral: Click or tap to enter a date. |
| **Corrective Action Plan**  Corrective Action taken: | | |
| **Complete Incident Report form and fax Martha Crownover, SBHO Incident Manager**  **Email: mcrownov@co.kitsap.wa.us**  **Fax: (360) 337-5721**  **Mail: 614 Division St. Port Orchard WA 98366**  **MS: #23**  **Phone: (360) 337-4648** | | |
| |  | | --- | | **RESOLUTION & CLOSURE** |   Resolution and Closure: The SBHO must resolve and close all incidents and report the outcome to DBHR within 45 business days after the incident was initially reported.  The SBHO will not close an incident unless all relevant follow-up information is recorded to the SBHO Incident Manager, including:   * A description of any incident-specific investigations, debriefings, witness interviews, clinical audits, and other process dispositions * A description of services provided to the Enrollee after the incident took place. * A description of relevant factor(s) contributing to the incident. * A description of any risk to Enrollees, the agency, the SBHO, or DSHS resulting from the incident. * A description of action steps the agency has taken to mitigate current circumstances and, if applicable, how it will prevent similar incidents from occurring in the future. | | |