

## Critical Incident Report Form

Details of where incident was discovered	
Identification of member affected:	Location of incident:
Member Name:	Facility (include address)
Member ID Number:	Department/Unit/Specialty:
Member Date of Birth:	Member PCP:
Time/Date of Incident:	Time/Date of Report:

Onsite Staff Involved:	
Name:	Title:

Nature of Incident: (Check all that apply)		
<input type="checkbox"/> Accidental Injury	<input type="checkbox"/> Unexpected Death	<input type="checkbox"/> Suicide/Homicide Attempt
<input type="checkbox"/> Unexpected Death	<input type="checkbox"/> Law Enforcement Contact	<input type="checkbox"/> Adverse Drug Reaction
<input type="checkbox"/> Restraint Injury	<input type="checkbox"/> Seclusion Injury	<input type="checkbox"/> Altercation Injury
<input type="checkbox"/> Allegations of Abuse	<input type="checkbox"/> Allegations of Neglect	<input type="checkbox"/> Allegations of Battery/Assault
<input type="checkbox"/> Member Elopement	<input type="checkbox"/> Medication Errors	<input type="checkbox"/> Other (detail below)
<input type="checkbox"/> BH – Sexual Contact	<input type="checkbox"/> BH – Unexpected Illness	<input type="checkbox"/> BH – Property Damage

Fax: (844)843-3890

Secure Email to: [NTCQUALITY@CENTENE.COM](mailto:NTCQUALITY@CENTENE.COM)

**Summary of Incident:** (Please state facts and attach separate sheet if necessary)

Ensure that all necessary steps have been taken to support/treat anyone injured and prevent injury to others.  
Ensure medical records are factual and up to date.

**Action Taken as a Result of Incident:** (Please give brief details and attach separate sheet if necessary)

**Thank you for answering these questions and joining Nebraska Total Care in our commitment to quality.**

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