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)		
☐Accidental Injury	☐Unexpected Death	☐Suicide/Homicide Attempt
☐Unexpected Death	☐Law Enforcement Contact	☐Adverse Drug Reaction
☐Restraint Injury	☐Seclusion Injury	☐Altercation Injury
☐Allegations of Abuse	☐Allegations of Neglect	☐Allegations of Battery/Assault
☐Member Elopement	☐Medication Errors	☐Other (detail below)
☐BH – Sexual Contact	☐BH – Unexpected Illness	☐BH – Property Damage

Fax: (844)843-3890
Secure Email to: 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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