SECURELY EMAIL ALL REPORTS TO CDHS_BHA_CI@STATE.CO.US

Agency Name:

Address: City:

Zip: Phone Number:

Critical Incident Type:

☐ Death ☐ Assault ☐ Medical Emergency

☐ Elopement ☐ Breach of Confidentiality

☐ Medication Diversion/Error

Date Critical Incident Occurred:

Date Critical Incident Discovered:

Date Critical Incident Reported to OBH:

Description of Critical Incident:

Client Demographic Information: Agency assigned client ID number

Age:

Gender:

- ☐ *Male*
- ☐ *Female*
- ☐ *Transgender Male*
- ☐ *Transgender Female*
- ☐ *Nonbinary*
- ☐ *Prefer not to disclose*

Race (if provided by client):

Level of Care (Outpatient, Inpatient, Meds Only, Community Crisis Services):

Detailed description of what transpired during the incident:

Facility Response to Critical Incident (action taken by staff to address the incident and any plans for follow up):

Report Prepared By: Title: Date: