

Office of Mental Health Programs 550 High Street, Suite 1000 Jackson, MS 30201 601-359-9545 FAX: 601-359-6294

## Psychiatric Residential Treatment Facility (PRTF) Incident Report Form – Confidential

## Please submit completed form via EMAIL to MSPRTF@TELLIGEN.COM

CECTION L. DEPORTING FACILITY AND DEPORTING DEPON			
SECTION I – REPORTING FACILITY AND REPORTING PERSON			
PRTF Name:	Form Completed By:		
Address:	Title: Investigator		
City, State, ZIP:	Phone Number:		
Risk Manager:	Case # (if applicable):		
Phone Number: Date faxed to DOM:			
SECTION II – RESIDENT INFORMATION			
Indicate if the resident/s involved are MS Medicaid beneficiaries and list their name/s below. List only the initials of any			
non-MS Medicaid residents.	This information has been disclosed to you from reco		
☐ MS Medicaid ☐ Non-MS Medicaid	Beneficiary whose confidentiality has been protect Statutes/regulations prohibit you from making furti		
Beneficiary	disclosure of it without the specific written consent of		
	person to whom it pertains, or as otherwise permitted such regulations. A general authorization for the rele		
Resident Name/Initials:	of medical or other information is not sufficient for t		
VICTIM:	purpose. The Federal Rules restrict any use of tinformation to criminally investigate or prosecute a		
SUSPECT:	alcohol or drug patient (42 CFR Part-2).		
SECTION III – INCIDENT INFORMATION			
Date Incident Occurred: Date Resident Reported to Staff:			
Day of Week Incident Occurred:MTWTH _	FSSU		
Type of incident (Check all that apply):	Staff Involved:		
☐ Serious Injury/illness requiring attention by in-house	Name:		
medical staff	Name:		
☐ Serious Injury/illness requiring outside medical	Name:		
attention	Name:		
☐ Injury resulting from physical restraint/seclusion	Name:		
☐ Harm to self			
☐ Physical assault by resident	Witnesses:		
Sexual contact by residents	Name:		
	Name:		
Sexual assault  Name:			
☐ Contraband found that could cause harm (illegal	Name:		
substances, lighter, etc.)	Name:		
☐ Substance use on facility grounds/supervised trip			
☐ Elopement	Where Incident Occurred:		
☐ Medication error requiring medical attention	□ PRTF		
☐ Suicide Attempt	□ School		
☐ Suicide	☐ Community		
☐ Mistreatment or allegations of mistreatment including	☐ Home		
but not limited to abuse, neglect, emotional harm, or	harm or		
sexual exploitation by staff	☐ Other (Explain):		
☐ Death			
☐Other (Explain):			

SECTION IV- NARRATIVE DETAILS				
Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants (resident, staff, etc.) and their involvement in the incident. Please be comprehensive but concise in explaining who, when, where, why, how, and what was heard and/or observed:				
SECTION V DIANTO DESO	IVE (INAMEDIATE AND LON	IC TERM)		
SECTION V- PLAN TO RESOLVE (IMMEDIATE AND LONG TERM)  At the time of the report, is the facility conducting an internal investigation?YesNo				
Updated reports should be submitted every 10 business days until the investigation is complete using the <b>Incident</b>				
Report Update Form				
Describe any corrective action taken to prevent future incidents (including changes to behavior care plan, treatment plan, or medication regimen, etc.):				
If mistreatment or allegations of mistreatment by staff, actions taken (training, suspension, termination, etc.):				
SECTION VI- INDICATE WHCH OF THE FOLLOWING AGENCIES AND INDIVIDUALS HAVE BEEN INFORMED				
Check all that apply and provide:				
☐ Parent/Legal Guardian	Name:	Date:		
☐ MS Department of Human Services (DHS)	Name:	Date:		
☐ MS Department of Health (MDH)	Name:	Date:		
☐ Disability Rights Mississippi (DRM)	Name:	Date:		
☐ Medicaid Fraud Control Unit, Attorney General	Name:	Date:		
(MFCU)	Name:	Date:		
☐ Center for Medicare/Medicaid Services (CMS)	Name:	Date:		
☐ DMH Office of Incident Management	Name:	Date:		
		-		
SECTION VII – ATTACHMENTS				
Are there attachments included with this report?YesNo				

This information has been disclosed to you from records confidentiality has been protected. Statutes/regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release Page 2 (of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug patient (42 CFR Part-2).