COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

CRITICAL INCIDENT REVIEW

Date of Incident Report:	**Date Reviewed by Quality Assurance:**
Reporting Agency/Program	**Quality Assurance Reviewer:**
Name of Individual:	**Case Number:**

INFORMATION SOURCES: (Use as indicated)

- ☐ Incident Report
- ☐ Interview with:
- ☐ Document review of:
- ☐ Other

					RELEVANT COMMENTS
Was the incident critical?	☐	Yes	☐	No	
Is the population reportable?	☐		☐		
Was the event unexpected?	☐		☐		
Did the event result in major permanent loss of limb or function?	☐		☐		
Was there risk of loss?	☐		☐		
Was there death or major permanent loss of function associated with a health care acquired infection?	☐		☐		
Should a formal investigation (including a root cause analysis) be conducted?	☐		☐		
If yes, who should be involved in that analysis?	☐		☐		
Are there any immediate recommendations for actions to be taken in order to prevent further occurrences?	☐		☐		
Should this event be reported as a sentinel event to: ☐ MDCH ☐ LBHA ☐ Accreditation	☐		☐		

SUMMARY OF INCIDENT: ______________________________

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SUMMARY OF FINDINGS: ______________________________

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REVIEWER'S SIGNATURE:______________________________ **DATE:**__________________

A177 (01/26/09)