



# ADDENDUM

Complete this form when additional pages are needed for the DMH-DD event or medication error report form.

**Event Date & Time** \_\_\_/\_\_\_/\_\_\_ : \_\_\_  AM  PM **Individual DMH ID#:** \_\_\_\_\_ **Event #** \_\_\_\_\_

<b>Persons Involved</b>	<b>Status:</b> Consumer , Staff , Other –specify in space below <b>Role:</b> Alleged Perpetrator, Complainant , Informant , On Duty Non-Witness, Person Making Error, Reporter, Victim, Witness					
	<b>Last Name</b> <i>Print or Type</i>	<b>First Name</b>	<b>Status</b>	<b>Role</b>	<b>SOP Only</b> <i>Staff SS # (last 4 digits)</i>	<b>Individual DMH ID #</b>

<b>Notifications</b>	<b>Notified Types:</b> 911, Agency Administrator, DSS, DHSS, DMH Facility Head, Local Law Enforcement ,Nurse, Physician, Service Coordinator, Other-Specify			
	<b>Notified Type</b>	<b>Contact Name &amp; Title</b>	<b>Date</b>	<b>Time</b> ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
				____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
				____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
				____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
				____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<b>Name of Guardian Notified</b>		<b>Related Individual's Name</b>	<b>Date</b>	<b>Time</b> ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
				____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM

<b>Event Description</b>	<b>Print or Type - Describe what happened, interventions used by staff or med error &amp; follow up action.</b>

<b>Medication Error</b>	<b>Individual's Name:</b>			
	<b>Current Physician Written Order</b> <i>(Record only meds in error as they appear on order)</i>	<input type="checkbox"/> Service provider may choose to attach current physician order & indicate only meds in error. Check box if provider is attaching the current physician order.		
	<b>Medication Name in Error/Form</b> <i>(Print or Type)</i>	<b>Quantity</b> <i>Amount given (0-if med was not given to individual)</i>	<b>Dosage</b> <i>Dose given (0-if med was not given to individual)</i>	<b>Variations</b> <i>How many consecutive times did the error occur?</i>
<input type="checkbox"/> See attached addendum for additional meds in error.				



# ADDENDUM

Complete this form when additional pages are needed for the DMH-DD event or medication error report form.

Event Date & Time \_\_\_\_/\_\_\_\_/\_\_\_\_ : \_\_\_\_AM \_\_\_\_PM Individual DMH ID#: \_\_\_\_\_ Event # \_\_\_\_\_

<b>Elopement</b>	<b>Individual's Name:</b>			
	<b>Left From</b>	<input type="checkbox"/> Supervised Activities	<input type="checkbox"/> Unsupervised Activities	<input type="checkbox"/> Other
	<b>Risk Type</b> <i>(Select all that apply)</i>	<input type="checkbox"/> Dangerous to Others	<input type="checkbox"/> Dangerous to Self	<input type="checkbox"/> Inability to Care for Self <input type="checkbox"/> Medical
	<b>Return</b>	Date of Return: _____ Time of Return: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM		

<b>Emergency Procedures (Restraints &amp; Time Out)</b>	<b>Individual's Name:</b>			
	<b>Staff/Person Initiating EP</b>	<b>Last Name:</b>	<b>First Name:</b>	
	<b>Behaviors Leading to EP</b> <i>(Select All That Apply)</i>	<input type="checkbox"/> Consumer Self Harm <input type="checkbox"/> Consumer Struck Object	<input type="checkbox"/> Elopement-Unlocked <input type="checkbox"/> Graphic Threat of Harm <input type="checkbox"/> Ingestion of non-food item	<input type="checkbox"/> PA-Consumer/Consumer <input type="checkbox"/> PA-Consumer/Other <input type="checkbox"/> PA-Consumer/Staff
	<b>Antecedent Events</b> <i>(Select All Previous Events That Apply)</i>	<input type="checkbox"/> Aggression by Others <input type="checkbox"/> Change in Daily Activity <input type="checkbox"/> Change in Living Environment <input type="checkbox"/> Conflict w/ peer <input type="checkbox"/> Crowding	<input type="checkbox"/> Holiday or Weekend <input type="checkbox"/> Instructed/Direction given <input type="checkbox"/> Instructed to start task <input type="checkbox"/> Interaction w/ peer <input type="checkbox"/> Lack of Supervision	<input type="checkbox"/> Limited Sleep <input type="checkbox"/> Noise or Chaotic Environment <input type="checkbox"/> Normal Routine <input type="checkbox"/> Normal Routine Interrupted <input type="checkbox"/> Nothing Observable
	<input type="checkbox"/> Other Consumer/s Acting Out <input type="checkbox"/> Physical Illness or Injury <input type="checkbox"/> Psychiatric Condition <input type="checkbox"/> Recent Med Change <input type="checkbox"/> Told No/Asked to Stop <input type="checkbox"/> Unfamiliar Staff			
	<input type="checkbox"/> Individual was hospitalized (unplanned) in a crisis situation for psychiatric evaluation/treatment as a result of the above behavior.			

*Use the event form description section to describe how all Emergency Procedures were implemented.*

Emergency Procedure Type	In Date	In Time	Out Date	Out Time	Involved Staff	Involved Staff
<input type="checkbox"/> Chemical Restraint						
<input type="checkbox"/> Manual Restraint						
<input type="checkbox"/> Mechanical Restraint						
<input type="checkbox"/> Time Out						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						

<b>Injury Description</b>	<b>Individual's or DD-DMH Staff Name:</b>				
	<b>Emergency Room Required?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<b>Injury Type</b> <i>(Select One)</i>	<input type="checkbox"/> Accident <input type="checkbox"/> Consumer Inflicted	<input type="checkbox"/> Self Inflicted <input type="checkbox"/> Staff Inflicted	<input type="checkbox"/> Other Inflicted <input type="checkbox"/> Unknown	
	<b>Injury Severity</b> <i>(Select One)</i>	<i>Injuries in these three categories must be reported.</i> <input type="checkbox"/> Death <input type="checkbox"/> Hospitalization <input type="checkbox"/> Medical Intervention		<i>Report only when associated with a DD Reportable Category.</i> <input type="checkbox"/> Minor First Aid <input type="checkbox"/> No Treatment	
	<b>Injury Type Description Legend</b>	<b>A</b> -Abrasion <b>B</b> -Bite <b>C</b> -Burn	<b>D</b> -Bruise/Contusion <b>E</b> -Complaint of Pain <b>F</b> -Cut/Laceration	<b>G</b> -Dislocation <b>H</b> -Fracture/Break <b>I</b> -Frostbite	<b>J</b> - Puncture <b>K</b> - Scratches <b>L</b> - Strain/Sprain
	<b>Injured Body Parts</b> <i>* Check all that apply</i>  <i>* Circle (R) Right or (L) Left</i>  <i>* Code each Injury with an Injury Type using the above description legend.</i>	<input type="checkbox"/> Head _____ <input type="checkbox"/> Face _____ <input type="checkbox"/> Eye R/L _____ <input type="checkbox"/> Ear R/L _____ <input type="checkbox"/> Nose _____ <input type="checkbox"/> Mouth _____ <input type="checkbox"/> Teeth _____ <input type="checkbox"/> Neck _____	<input type="checkbox"/> Shoulder R/L _____ <input type="checkbox"/> Upper Arm R/L _____ <input type="checkbox"/> Elbow R/L _____ <input type="checkbox"/> Forearm R/L _____ <input type="checkbox"/> Wrist R/L _____ <input type="checkbox"/> Hand R/L _____ <input type="checkbox"/> Chest _____ <input type="checkbox"/> Upper Back _____	<input type="checkbox"/> Lower Back _____ <input type="checkbox"/> Abdomen _____ <input type="checkbox"/> Waist _____ <input type="checkbox"/> Hip R/L _____ <input type="checkbox"/> Genitals _____ <input type="checkbox"/> Buttock R/L _____ <input type="checkbox"/> Thigh R/L _____	<input type="checkbox"/> Knee R/L _____ <input type="checkbox"/> Calf R/L _____ <input type="checkbox"/> Shin R/L _____ <input type="checkbox"/> Ankle R/L _____ <input type="checkbox"/> Foot R/L _____ <input type="checkbox"/> Other (specify) _____

FINGERS	TOES
<input type="checkbox"/> Thumb R/L _____	<input type="checkbox"/> Big R/L _____
<input type="checkbox"/> Index R/L _____	<input type="checkbox"/> 2 <sup>nd</sup> R/L _____
<input type="checkbox"/> Middle R/L _____	<input type="checkbox"/> 3 <sup>rd</sup> R/L _____
<input type="checkbox"/> Ring R/L _____	<input type="checkbox"/> 4 <sup>th</sup> R/L _____
<input type="checkbox"/> Little R/L _____	<input type="checkbox"/> Little R/L _____

<b>Death</b>	<b>Individual's Name:</b>		
	<b>Was death expected?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Suspected Manner of Death</b>	<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Natural <input type="checkbox"/> Undetermined
	Date of Death: _____ Time of Death: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM		