Critical Incident Report Form

Client Name: _____**Client DOB**: _____ **Date:** _____

Provider/Facility: Favored Healthcare Services **Provider Phone:** 770-932-4932 **Provider Fax:** 404-418-8051

Provider Email: Favoredhealthcareservices@gmail.com

Administrator/Staff completing report: _____

Type of Incident (check all that apply)

___Abuse: ___Physical ___Verbal ___Sexual ___Mental ___Client to Client ___Staff to Client

___Neglect: ___Exploitation ___Other:_____

___Death: ___Unexpected ___Expected ___Hospice Enrolled ___911 called (Time_____
___Initiated CPR by (staff name_____)

___Fall/Injury: ___Resulted in death ___Hospital Admission ___ER Visit ___MD Visit ___Treated on site

___External Disaster: ___Fire ___Flood ___Damage to Home/ADH ___Client Relocated

___Elopement: ___Police Notified (Date _____Time _____) ___Individual has memory impairment

___Client returned/located ___Client has safe return bracelet

Date of Incident:_____ Time of Incident: _____ Location of Incident:_____

Details of Incident/Type (and/or) description of injury: __Bruise __Laceration __Head Injury __Fracture __Other
Specify:_____

_____

Contributing Factors (Check all that apply)

Lack of supervision		Paralysis		Balance Deficit		Incontinence	
Failed to use DME		Cognitive Impairment		Medication		Illness	
Gait Deficit		Progress Musc. Dis.		Progress Neurolog Dis.		Pain	
Poor Vision		Other:					

Family Involved		Hospital		ER Visit	
Police		MD Visit		Mental Health Evaluation	

Initial Response (Check all that apply)

Notifications		**Date**	**Time (am or pm)**	**Name**
Family/Guardian/Resp Party				
Physician				
Police				
APS				
Care Coordinator				

Other:

Corrective Action: How to prevent injury in the future?

_____

Client's Folder Check List

		Yes __	No___	Action taken
1.	Nursing Assessment			
2.	Advance Directive Checklist			
3.	Client's Rights and Responsibilities			
4.	Medication List			
5.	Admission Agreement Form			
6.	Service Agreement Contract			
7.	Emergency Medical Treatment			
8.	Client Service Plan Form			
9.	Client Emergency Information			
10.	Request For Services			
11.	HIPPA Privacy			
12.	Authorization and Consent for Automobile Release of Liability			
13.	Grievance/Complaint Procedure			
14.	Authorization For Release of Information			
15.	Client's Homecare Worker Services/Provider Information			
16.	Critical Incident Report Form			
17.	Fall Risk Assessment Form			
18.	Home Safety Checklist			
19.	After Hours Coverage/Emergency Plan			
20.	Service Care Plan			
21.	Client Care Plan			
22.	Supervisory Visit Form			
23.	Miscellaneous Documents			
•	Weekly Task Sheet			
•	Progress Note			
•	Referral Packet			
24.	Service Plan Review Form			
25.	Time Sheets			
26.	Physician Order			

Audit:_____ **Date:** _____

Audit:_____ **Date:** _____

Audit:_____ **Date:** _____

Audit:_____ **Date:** _____

Audit:_____ **Date:** _____

Audit:_____ **Date:** _____

DISCHARGE INFORMATION

CLIENT'S NAME: _____ SS#: _____

DIAGNOSIS: _____

_____

_____

CURRENT SERVICES BEING RECEIVED: _____

_____

SERVICES PROVIDED BY WHOM: _____

REHABILITATION POTENTIAL: _____

COURSE OF PRIOR SERVICE: _____

_____

DIET: _____

ACTIVITIES: _____

RESTRICTION: _____

_____

REFERRED TO OTHER SERVICES? [ ] YES [ ] NO (INCLUDED COMMUNITY RESOURCES):

_____

_____

CONCERNS/NEEDS COMMENTS (UNRESOLVED GOALS): _____

_____

REASON FOR DISCHARGE: _____

_____

_____

[ ] FORM DISCUSSED WITH CLIENT OR CARETAKER

[ ] PHONE INSTRUCTIONS GIVEN TO _____

[ ] COPY OF CURRENT CARE PLAN GIVEN WITH THIS FORM

[ ] COPY OF CURRENT CARE PLAN & DISCHARGE INSTRUCTIONS LEFT IN HOME

[ ] COPY OF CURRENT CARE PLAN & DISCHARGE INSTRUCTIONS MAILED TO HOME

_____ _____

PROFESSIONAL NAME & TITTLE DATE

_____ _____

CLIENT/RESPONSIBLE PARTY DATE

MEMBER DISCHARGE FORM

Member Name: _____Date_____

Member Address: _____

_____

Member Telephone: _____

Member Medicaid #_____

Social Security #_____

Date Services Begin _____ Date Services End_____

Member Triage Level: Triage I [ ] Triage II [ ] Triage III [ ] Triage IV [ ]

Member Date of Discharge_____

Reason(s) for the Discharge

Please give reason(s) why member is discharged in the space provided

_____

_____

_____

_____

Member has been discharged from Favored Healthcare Services for the reason(s) given or provided above. Any questions should be directed to Favored Healthcare Services Case Manager

Approved By: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I hereby authorize: **Favored Healthcare Services**
4297 Buford Dr. Ste. 2B
Buford, Ga 30518

To obtain from: _____
(Name of Person, Healthcare provider or Agency Holding the Information)

_____
(Address)

For the purpose of: _____

_____

Any and all medical records ☐ Referrals ☐

Copies of Prescriptions ☐ Lab Results ☐

1. I understand that my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.
2. All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent.
3. I also understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.
4. I intend this document to be a valid authorization conforming to all requirements of the PRIVACY RULE and state law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

One (1) year ☐ ☐
The period necessary to complete all transaction on matters related to services provided to me.
I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time by sending written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to the Department's Privacy Officer at 2 Peachtree St. NE, STE. 22.240 Atlanta, Ag 30303-3124

X_____ _____
Signature of Client Date

X_____ _____
Signature of Witness (title or Relationship to Individual) Date

Complaint Report

Name: _____ Date: _____

Client Name: _____ Time: _____

Caregiver: _____

Who is making the complaint? _____

What is the complaint? (Be specific)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Who received the complaint? _____

What actions were taken by Favored Health Care?_____

_____
_____
_____
_____

X _____ X _____

Signature Date

X _____ X _____

Chibueze Okwaraoha Date

Handling/Resolution of Complaint, Accident or injuries

Complainant Name: _____

Address: _____

Tel Number ( )_____ Other ( )_____

Date of Complaint _____ Time of Complaint _____

Description of Complaint/Incident

_____

_____

_____

_____

_____

_____

_____

To whom was the complaint made to _____

What type of resolution/Action taken

_____

_____

_____

_____

Was complaint received by mail _____ Phone _____ Oral _____

Was complaint resolved? [ ] Yes [ ] No Date: _____

If complaint is resolved, how and explain in full detail:

_____

_____

_____

Signature _____ Signature _____

Favored Healthcare Services Client/responsible Party

Date: _______________________ Date: ______________________

File Notes Client Name: ____

DATE	COMMENTS
