ADULT MENTAL HEALTH DIVISION
Performance Improvement
Consumer Sentinel Event Report
Immediate Notification

Complete the blanks as thoroughly as possible. Use an X mark in the boxes ☒ as appropriate.
Performance Improvement Fax Number: 808-453-6995 (Fax within one (1) business day of the event.)

1. Consumer's Name: (Last) ___________________ (First) __________________

2. Sex: Male ☐ Female ☐ 3. Date of Birth: _____
mm/dd/yyyy

4. Last Four of Consumer's Social Security Number: _____

5. Date of Sentinel Event: _____ Date Provider notified: _____
mm/dd/yyyy mm/dd/yyyy

6. Sentinel Event Brief Description
_____

Event List:

1. ☐ Suicide of a consumer.
2. ☐ Homicide of a consumer.
3. ☐ Homicide by a consumer.
4. ☐ Medication error: any consumer death, paralysis, coma, or a permanent loss of function associated with a provider medication error.
5. ☐ Serious consumer injury resulting in permanent loss of limb or function or risk thereof.
6. ☐ Suspected abuse or neglect of a consumer.
7. ☐ Sexual assault of or by a consumer.
8. ☐ Attempted suicide of a consumer that required medical intervention.

9. ☐ Attempted homicide of or by a consumer.

10. ☐ Physical assault of staff or citizen or another consumer, by a consumer, resulting in permanent loss of limb or function or risk thereof.

11. ☐ Accidental death of a consumer that resulted directly from a physical injury while in Hawaii State Hospital (HSH), an AMHD contracted inpatient bed, or in an AMHD contracted community residential placement.

12. ☐ Elopement (24 hours or more) from HSH or Kahi Mohala contracted inpatient bed only for consumers who are currently inpatient.

13. ☐ Revocation of Conditional Release.

14. ☐ Arrest or incarceration of a consumer.

15. ☐ Psychiatric hospitalization of a forensically encumbered consumer.

16. ☐ MH-1 evaluation of a forensically encumbered consumer.

17. ☐ Elopement (24 hours or more) from an AMHD contracted community residential placement by a forensically encumbered consumer.

7. Place of Sentinel Event: _____

8. Legal Status:

a. ☐ 704 - 404	d. ☐ 704 - 411(1) (b)	i. ☐ Probation
b. ☐ 704 - 405	e. ☐ 704 - 413	j. ☐ Voluntary
c. ☐ 704 - 406	f. ☐ 704 - 415	m. ☐ MH4-MH6-MH9
d. ☐ 704 - 406 (1) (a)	g. ☐ 706 - 607	n. ☐ Other (specify)
e. ☐ 704 - 411 (1) (a)	h. ☐ Parole	_____

9. Date of discharge from HSH or AMHD contracted inpatient bed (if within 30 days of discharge) mm/dd/yyyy _____

10. Primary Psychiatric Diagnoses: _____

11. Physical/Medical Conditions: _____

12. Current Medications (List names and doses): _____

13. Level of Case Management: _____

14. Case Management agency: _____

15. Housing Agency: _____

16. Date of last face-to-face contact with case manager prior to event: _____
mm/dd/yyyy

17. Date of last face-to-face contact with psychiatrist prior to event: _____
mm/dd/yyyy

18. Date of last face-to-face contact with housing staff prior to event: _____
mm/dd/yyyy

19. Psychiatrist:
   a. ☐ POS
   b. ☐ CMHC
   c. ☐ HSH
   d. ☐ Private Psychiatrist
   e. ☐ VAMHC

20. Island Services Received: _____

21. Housing Type: _____

Please complete the following information about your agency:

22. Agency completing the form: __________________

23. Program name: _______________

24. Reported by (Name, Title): __________________ **Date:** _____
mm/dd/yyyy

25. Phone number: ____________

26. Fax number: ____________

27. Date form completed: _____