



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

Compete the blanks as thoroughly as possible. Use an X mark in the boxes as appropriate.

Performance Improvement Fax Number: 808-453-6939 (Fax within one (1) business day of the event.)

1. Consumer's Name: (Last) _____ (First) _____

2. Sex: Male Female 3. Date of Birth: _____

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

5. Date of Sentinel Event: _____ Date Provider Notified: _____

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 | f. 704 - 411 (1)(b) | k. Probation |
| b. 704 - 405 | g. 704 - 413 | l. Voluntary |
| c. 704 - 406 | h. 704 - 415 | m. MH4-MH6-MH9 |
| d. 704 - 406 (1)(a) | i. 706 - 607 | n. Other (specify) |
| e. 704 - 711 (1)(a) | j. Parole | _____ |

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

10. Primary Psychiatric Diagnosis: _____

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: _____
17. Date of last face-to-face contact with psychiatrist prior to event: _____
18. Date of last face-to-face with housing staff prior to event: _____
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: _____

25. Phone Number: _____ 26. Fax number: _____

27. Date form completed: _____