



**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. <input type="checkbox"/> 704 - 404 | d. <input type="checkbox"/> 704 - 411(1) (b) | i. <input type="checkbox"/> Probation |
| b. <input type="checkbox"/> 704 - 405 | e. <input type="checkbox"/> 704 - 413 | j. <input type="checkbox"/> Voluntary |
| c. <input type="checkbox"/> 704 - 406 | f. <input type="checkbox"/> 704 - 415 | m. <input type="checkbox"/> MH4-MH6-MH9 |
| d. <input type="checkbox"/> 704 - 406 (1) (a) | g. <input type="checkbox"/> 706 - 607 | n. <input type="checkbox"/> Other (specify) |
| e. <input type="checkbox"/> 704 - 411 (1) (a) | h. <input type="checkbox"/> 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: _____