The ROF form must be typed. Handwritten reports will be returned to programs for a typed [report.](https://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5079.pdf) [All fields are required](https://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5079.pdf) and must be completed unless otherwise noted. Incomplete form may be returned. For questions or consultation regarding ROF’s or reporting incidents, contact BHS QA via QI Matters email: qimatters.hhsa@sdcounty.ca.gov.

See ROF FAQ/Tip Sheet posted on the Optum site for additional details for completing the ROF Form and reporting to BHS QA. Located under “Incident Reporting” tab on the SMH & DMC-ODS Health Plan Optum page.

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| 1. **PROGRAM REPORTING CRITICAL INCIDENT**

*Provide details about program reporting CIR/ROF, including staff completing/submitting the CIR form.*  |
| Program Type | Click to view/select options |
| Agency/Legal Entity Name |       |
| Program Name |       |
| Program Manager Name  |       |
| Program Manager Email |       |
| Program Manager Phone Number |       |
| Staff Name Reporting ROF |       |
| Date Staff Reporting |       |
| Contracting Officer Representative (COR) |       |
| Contract # *(if known or available)* |        |

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| 1. **INCIDENT INFORMATION**

*Provide details about the incident: date of incident, ROF submission dates; RCA requirements and date*  |
| Date of Incident |       |
| Was ROF submitted to QA within 30 days of the reported incident?  | [ ]  Yes [ ]  No |
| If no, why?  |       |
| Is RCA required?  | [ ]  Yes [ ]  No |
| If yes, date RCA completed |       |

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| 1. **CLIENT INFORMATION**

*Provide details about the client involved in the incident: client name; electronic health record number; custody info. Note: If OOC Client or Non-BHS Client, this section is not required.* |
| Client Name |       |
| EHR number, if applicable |       |
| Was the person in custody within the last 30 days?  | [ ]  Yes [ ]  No |

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| 1. **OVERDOSE INFORMATION**

*Complete the following for critical incidents related to an overdose.* *If incident not related to overdose, indicate here:* ​ [ ]  ​ N/A |
| 1. Substance involved in the overdose
 | Click to view/select optionsOther:       |
| 1. If Opioid was involved, was the client receiving Mediation Assisted Treatment (MAT) services
 |  [ ]  Yes [ ]  No |
| 1. If yes, was the client referred to MAT?
 |  [ ]  Yes [ ]  NoReferred to:       |
| 1. If client was not referred to MAT or declined a referral to MAT, please explain:
 |       |
| 1. Was Naloxone/Narcan administered?
 |  [ ]  Yes [ ]  NoBy whom:       |
| 1. Was fentanyl specific testing included in all client urine drug screens?
 |  [ ]  Yes [ ]  NoDate of most recent fentanyl specific test:       |
| 1. If yes, result of most recent fentanyl specific test
 | Click to review/select options |
| 1. Was the client given health education about Naloxone/Narcan for overdose prevention as part of treatment prior to the incident (i.e., intake)?
 | [ ]  Yes [ ]  No |
| 1. Was Naloxone/Narcan kit prescribed or given to the patient for overdose prevention prior to the incident (not including any staff administration of naloxone)?
 | [ ]  Yes [ ]  No |

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| 1. **CRITICAL INCIDENT OF SUMMARY FINDINGS RESULTS AND RECOMMENDATIONS**

*Describe the results of your investigation and recommendations as a result of the critical incident.* *NOTE: Section not required if RCA was complete; indicate N/A* [ ]  *for this section and complete section 6 below.*  |
| 1. Describe the results of your investigation and analysis of the serious incidence
 |
|       |
| 1. Describe recommendations or planned improvements including a summary of quality/system improvements as a result of the analysis of the critical incident.
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|       |

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| 1. **ROOT CAUSE ANALYSIS (RCA)**

*If required, provide details for RCA if an RCA has been completed: if root cause was identified, findings and action items.* *If RCA has not been completed, indicate N/A* [ ]  |
| 1. Was a root cause identified?
 | [ ]  Yes [ ]  No |
| 1. RCA Summary of Findings
 |
|       |
| 1. RCA Summary of Action Items
 |
|       |

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| 1. **PROGRAM MANAGER ATTESTATION**

*This section shall only be completed by Program Manager or Designee Only; select only one option.* |
| [ ]  I am the Program Manager and am attesting that the information provided is accurate. [ ]  I am submitting on behalf of the Program Manager and am attesting that the information provided is accurate and has been reviewed with the Program Manager.  |