The SIR 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 forms may be returned.

# For questions or consultation regarding SIR’s or reporting incidents, contact BHS QA at 619-584-3022 or email QI Matters: qimatters.hhsa@sdcounty.ca.gov.

See SIR FAQ/Tip Sheet posted on the Optum site for additional details for completing the SIR Form and reporting to BHS QA. Located under “Forms” tab on under the MHP and DMC Optum pages.

|  |
| --- |
| 1. **PROGRAM REPORTING SIR**

*Provide details about program reporting SIR, including staff completing/submitting the SIR form.* * *Level One: Fax/email within 24 hours*
* *Level Two: Fax/email Level within 72 hours*
 |
| Agency/Legal Entity Name |       |
| Program Name |       |
| Program Manager Name  |       |
| Program Manager Email |       |
| Program Manager Phone Number |       |
| Program Type (MH) | Click to view/select optionsIf “other” selected:       |
| Program Type (SUD) | Click to view/select options If “other” selected:       |
| Name of Staff Reporting |       |
| Date Staff Reporting |       |
| Region | Click to view/select options |
| Contracting Officer Representative (COR) |       |

|  |
| --- |
| 1. **INCIDENT SEVERITY**

*Indicate severity level of incident* |
| [ ]  **LEVEL ONE** | [ ]  **Level Two**  |

|  |
| --- |
| 1. **PHONE REPORTING**

*Provide details about when SIR was reported vis SIR Report line: date/time** *Level 1 = Phone report* ***immediately,*** *upon knowledge of the incident.*
* *Level 2 = Phone report within* ***24 hours****, upon knowledge of the incident*
 |
| Date/Time of Phone Reporting | Date:       Time:       |

|  |
| --- |
| 1. **CLIENT INFORMATION**

*Provide details about the client involved in the incident: client name and DOB; DSM dx; client record number for CCBH or SanWITS; last date of service; if client has MC, indicate with MC #.*  |
| Client Name |       |
| DOB |       |
| DSM-5 Diagnosis |       |
| CCBH Number |       |
| SanWITS Number |       |
| Date of Last Service |       |
| Does the client have Medi-Cal (MC)?  | [ ]  Yes [ ]  NoIf yes, MC #:       |
| Is the client involved with or connected to other departments or entities?  | [ ]  Yes [ ]  NoIf yes, section 6 below must be completed.  |

|  |
| --- |
| 1. **INCIDENT INFORMATION**

*Provide details about the incident: date/time, location of incident; staff involved in the incident; date incident reported to the program; type of incident (use drop down menu); if reported to media, include relevant material or links to news stories;*  |
| Date of Incident |       |
| Time of Incident  |       [ ]  Unknown  |
| Location of Incident |       |
| Staff Involved with incident |       |
| Date Reported to Provider |       |
| Incident Type | Click to view/select optionsIf “other” selected:       |
| Did the incident involve media? If yes, include media links required for all incidents.  | [ ]  Yes [ ]  No      |

|  |
| --- |
| 1. **NOTIFICATIONS**

*Indicate other departments/parties notified regarding the incident with date/time of notification.* *If notification is not required for the client, indicate here:* [ ]  N/A  |
| **a)** | Entity: Click to view/select optionsIf “other” selected:       | Date:       Time:       | Notification Type: Click to view/select options |
| **b)** | Entity: Click to view/select optionsIf “other” selected:       | Date:       Time:       | Notification Type: Click to view/select options |
| **c)** | Entity: Click to view/select optionsIf “other” selected:       | Date:       Time:       | Notification Type: Click to view/select options |
| **d)** | Entity: Click to view/select optionsIf “other” selected:       | Date:       Time:       | Notification Type: Click to view/select options |
| **e)** | Entity: Click to view/select optionsIf “other” selected:       | Date:       Time:       | Notification Type: Click to view/select options |
| **f)** | Entity: Click to view/select optionsIf “other” selected:       | Date:       Time:       | Notification Type: Click to view/select options |

|  |
| --- |
| 1. **NOTIFICATIONS (SUD RESIDENTIAL ONLY)**

*Report to DHCS SIRs related to death, injury that requires medical treatment, communicable diseases, poisonings, natural disaster and/or fires or explosions on premises. If notification is not required, indicate here:* [ ]  N/A |
| Death/Injury that required medical treatment, communicable diseases, poisonings, natural disaster and/or fires or explosions on the premise?  | [ ]  Yes [ ]  No |
| Telephonic Report (916) 322-2911 (within 24 hours) | Date:       Time:       |
| If Applicable, Written (Within 7 days of the Event)[DHCS 5079 titled “Unusual Incident/Injury/Death Report”](https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-5079-Unusual-Incident-Report.pdf) | [ ]  Yes [ ]  No |
| If Applicable, death report submitted via fax to the DHCS Complaints and Counselor Certification Division at (916) 445-5084 or by email to DHCSLCBcomp@DHCS.ca.gov  | Date:       Time:       |

|  |
| --- |
| 1. **DESCRIBE THE SERIOUS INCIDENT**

*Describe in detail the serious incident, addressing all items below.*  |
| 1. People involved, precipitating factors, and details of incident
 |
|       |
| 1. Indicate if client was admitted for medical or psychiatric care as a result of the incident
 |
|       |
| 1. Describe any physical, medical, or other concerns as a result of the incident
 |
|       |

|  |
| --- |
| 1. **OTHER BEHAVIORAL HEALTH CLIENT SERVICES**

*Indicate other services the client is receiving; example: Outpatient, FSP/ACT, WRAP, SBCM, medication management, day treatment, residential, recovery services, etc.* |
|       |

|  |
| --- |
| 1. **MEDICAL/PHYSICAL HEALTH OF THE CLIENT**

*List any known medications the client is prescribed, the name of the prescribing physician, and any medical conditions*. |
| Current prescribed medication(s) |       |
| Name of prescribing physician |       |
| Physical or medical conditions |       |

|  |
| --- |
| 1. **TARASOFF**

*Select the appropriate response for the Tarasoff question. Note: Program is not required to submit a report of findings for Tarasoff reports unless it is relevant to an identified systemic issue in program operations or to client’s treatment.*  |
| Tarasoff report of findings indicated? | [ ]  Yes [ ]  No |

|  |
| --- |
| 1. **PROGRAM MANAGER ATTESTATION**

*This section shall only be completed by Program Manager or Designee Only* |
| [ ]  By checking this box, I       attest that on this date       I have read and agree with the information included in this Serious Incident Report.  |