

**OhioMHAS  
Licensure and Certification**

**Major Unusual Incident Notification Private Psychiatric Service Providers**

You may submit & track electronically on the Web-Enabled Incident Reporting System at: <https://weirs.mh.state.oh.us> or Facsimile (614) 485-9739 – Licensure and Certification. This information is subject to a public record request.

<b>Private Psych. Incident No.</b>		<b>ODMH Incident No.</b>	
<b>Date of Discovery</b>	<b>Date of Report</b>	<b>Time of Report</b>	
<input type="checkbox"/> AM <input type="checkbox"/> PM			
<b>Facility Name</b>			
<b>Address</b> (street, city, state, zip)			
<b>Name of Contact and Phone Number Regarding Incident</b>			
( )			
<b>Date of Incident</b>	<b>Time of Incident</b>	<b>Census at Time of Incident:</b>	<b>Number of Staff at Time of Incident:</b>

**Location of Incident** (select one)

<input type="checkbox"/> Bathroom/Shower	<input type="checkbox"/> Seclusion Room
<input type="checkbox"/> Corridor	<input type="checkbox"/> Stairway
<input type="checkbox"/> Day Hall	<input type="checkbox"/> Recreation Area
<input type="checkbox"/> Dining Area	<input type="checkbox"/> Office
<input type="checkbox"/> Kitchen	<input type="checkbox"/> Outside
<input type="checkbox"/> Nursing Station	<input type="checkbox"/> AWOL/Community
<input type="checkbox"/> Program Area	<input type="checkbox"/> Unknown
<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Other, specify
<input type="checkbox"/> Patient's Room	

**Immediate Notifications of Incident** ("X" all that apply)

<input type="checkbox"/> Coroner	<input type="checkbox"/> ODMH
<input type="checkbox"/> Family/Guard/Spouse	<input type="checkbox"/> Protective Agency
<input type="checkbox"/> Local Board	<input type="checkbox"/> Risk Management
<input type="checkbox"/> Local Police	<input type="checkbox"/> Medical Director
<input type="checkbox"/> Director of Nursing	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Physician	<input type="checkbox"/> Other:

<b>Person Making Notification</b>	<b>Date</b>	<b>Time</b>
		<input type="checkbox"/> AM <input type="checkbox"/> PM

**Immediate Action Taken** ("X" all that apply)

<input type="checkbox"/> Evacuation of Area	<input type="checkbox"/> Transferred to Medical Floor
<input type="checkbox"/> First Aid	<input type="checkbox"/> Use of Force, specify
<input type="checkbox"/> Seclusion/Restraint	<input type="checkbox"/> Other, specify
<input type="checkbox"/> X-Rays	

<b>Root Cause Analysis Applicable</b>	<b>Race/Ethnicity Codes</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	A = Asian
<b>Injury Codes</b>	B = Black/African American
A=Abrasion	H = Hispanic
H=Fracture/Dislocation	M =Alaskan Native
B=Bite	N = Native Am./Am. Indian
I=Laceration	P = Native Hawaiian/Other Pacific Islander
C=Bruise	W=White
J=Scratch	M=None
D=Burn	N=Other:
K=Sprain	U= Unknown
E=Discoloration	
L=Swelling	
F=Dislocation	
M=None	
G=Fracture	
N=Other:	

**Type of Incident**

Medical Events Impacting Hospital Operations

Temporary Relocation of Patients

Involuntary Termination without Appropriate Patient Involvement

<b>Persons Involved or Patient Identifier</b>	V = Voluntary	E = Employee	P = Perpetrator	Race (see codes above)	Date of Birth	Gender M= Male F=Female	Injury Codes (list all that apply; see codes above)
	I = Involuntary	P = Patient	V = Victim				
1.							/ / / / /
2.							/ / / / /
3.							/ / / / /
4.							/ / / / /

**Additional Information:**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Time**  AM  PM

**Type of Incident**  Initial  Amended  
Please complete this form in its entirety

**Patient Fall**  **Injury Requiring:**

Hospitalization

Unplanned Emergency /Medical Intervention

**Adverse Drug Reaction that results in:**

Permanent Patient Harm  Death

Transfer to a Hospital Medical Unit

**Alleged Abuse of Patient**

Physical  Verbal  Sexual

Defraud  Neglect

**Assault by Non-Staff**

Physical Assault  Sexual Assault

Visitor  Patient  Other:

**AWOL (AWOL)**

Date: \_\_\_\_\_ Time Located: \_\_\_\_\_  AM  PM

Place Located: \_\_\_\_\_

**Attempted Suicide**  **Suicide** **Method:**

Asphyxiation  Drowning

Drug Overdose  Firearm

Hanging  Jumped from Height

Jumped in front of Moving Vehicle

Laceration  Poison

Other:

**Self-Injurious Behavior**

**Medication Error**  
that results in permanent patient harm, transfer to a hospital medical unit or death

**Death**

Accidental  Homicide by Patient

Homicide of Patient  Natural

**Discharge to Homeless**

Street  Shelter:

**Seclusion**  **Restraint** **Total Minutes:**

**Inappropriate Use of Seclusion / Restraint**

Mechanical Restraint  Physical Restraint

Transitional Hold  Seclusion

**Inappropriate Restraint Technique / Use of Force**

Unpleasant or Aversive Stimuli Intervention

Restriction of Ability to Communicate

Obstruction of Vision  Chemical Restraint

Weapons and Law Enforcement Restraint Devices

Obstructs Airway / Breathing

**Related Injury to Patient**

First Aid Required

Unplanned / Emergency Medical Intervention

Hospitalization Required

**Related Injury to Staff**

First Aid Required

Unplanned / Emergency Medical Intervention

Hospitalization Required

**Related Death**

Death during Seclusion or Restraint

Death within 24 hours of Seclusion or Restraint

Death related to or result of Seclusion or Restraint