VERMONT

State of Vermont
Department of Health
Div. of Alcohol and Drug Abuse Programs
108 Cherry Street–PO Box 70
Burlington, VT 05402-0070
HealthVermont.gov

[phone] 802-651-1550
[fax] 802-651-1573

Agency of Human Services

Critical Incident Form

Please complete this Form and Submit to ADAP within 24 hours of notification of Critical Incident

A. Background Information

Patient's Date of Birth: _____

Patient's ZIP Code of Residence: _____

Patient's Sex: ☐ Male ☐ Female

Patient's Admission Date: _____

Approximate Date of Death: _____

If enrolled in OTP or Office Based MAT program (If not, continued on to B)

Last Time Dosed/Prescribed at Clinic: _____

Medication Prescribed: ☐ Methadone ☐ Suboxone ☐ Subutex Last Dose: _____Mgs

Number of Take-Home Doses Dispensed/Tablets Prescribed at Last Visit: _____

Phase of Treatment (e.g. Induction, maintenance, etc.): _____

B. Most Recent Urine Drug Screen (UDS): _____

UDS Positive For (if any): _____

Current Level of Care (e.g. IOP, OP) _____ Current services (e.g. Group, 1:1): _____

Recent Level(s) of care: _____

C. Medical and Psychiatric Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

D. Type of Critical Incident:

☐ Significant Injury to Patient
☐ Significant Injury Caused by Patient
☐ Abuse Report
☐ Overdose (Non-Lethal)
☐ Significant Medication Error
☐ Staff Injury by Patient
☐ Potential Medial Involvement
☐ Death

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E. If Death, Please indicate Preliminary (P) or Confirmed (C) Underlying Cause/Mechanism of Death:

☐ Unknown	☐ Preliminary	☐ Confirmed
☐ Overdose	☐ Preliminary	☐ Confirmed
☐ Motor Vehicle Accident	☐ Preliminary	☐ Confirmed
☐ Other Type of Accident	☐ Preliminary	☐ Confirmed
☐ Homicide	☐ Preliminary	☐ Confirmed
☐ Suicide	☐ Preliminary	☐ Confirmed
☐ Trauma	☐ Preliminary	☐ Confirmed
☐ Cancer	☐ Preliminary	☐ Confirmed
☐ Cardiovascular	☐ Preliminary	☐ Confirmed
☐ COPD	☐ Preliminary	☐ Confirmed
☐ Diabetes	☐ Preliminary	☐ Confirmed
☐ HIV/AIDS	☐ Preliminary	☐ Confirmed
☐ Kidney Disease	☐ Preliminary	☐ Confirmed
☐ Liver Disease	☐ Preliminary	☐ Confirmed
☐ Seizures	☐ Preliminary	☐ Confirmed

☐ Other: _____

F. List of known OTC and Prescription Medications at the Time of Last Visit:

Medication Name: _____ Strength: _____ Dose: _____ Frequency: _____

Medication Name: _____ Strength: _____ Dose: _____ Frequency: _____

Medication Name: _____ Strength: _____ Dose: _____ Frequency: _____

Medication Name: _____ Strength: _____ Dose: _____ Frequency: _____

Medication Name: _____ Strength: _____ Dose: _____ Frequency: _____

G: Description of Event:

(Please provide a detailed description of the factors, including where the vent occurred, if others were involved, how the event was discovered, list of illicit drugs involved, etc.). If more space is needed, use a continuation sheet:

_____

_____

_____

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_____

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_____

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H: Other Relevant Medical History (e.g. Allergies, Pregnancy, Preexisting Medical Condition etc.):

I: Other Relevant Information (e.g. Other Service Providers, Legal Status etc.):