



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

In accordance with standards 11.16, all critical incidents including serious illness and/or injuries resulting in medical care as a result of services delivered or on the premises, or death shall be submitted to the ADAP Clinical Services Director within 24 hours of notification of critical incident. Forms can be faxed to **802-652-2019**

Report Date: _____ Incident Date: _____

Program Name: _____

Name of Person Completing Form: _____

A. Type of Critical Incident

- | | |
|---|---|
| <input type="checkbox"/> Significant injury to patient | <input type="checkbox"/> Significant medication error |
| <input type="checkbox"/> Significant injury caused by patient | <input type="checkbox"/> Abuse report |
| <input type="checkbox"/> Overdose (non-lethal) | <input type="checkbox"/> Staff injury by patient |
| <input type="checkbox"/> Potential medical involvement | <input type="checkbox"/> Death |

B. Demographic Information

Patient's date of birth: _____

Patient's ZIP code of residence: _____

Patient's sex: Male Female

Patient's admission date: _____

If enrolled in OTP or office-based MAT program (if not, continue 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.): _____

C. 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: _____

D. Medical and Psychiatric Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

E. If death, please indicate Preliminary (P) or Confirmed (C) underlying cause/mechanism of death:

- | | | |
|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Overdose | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Other type of accident | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Homicide | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Preliminary | <input type="checkbox"/> Confirmed |
| <input type="checkbox"/> 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: _____



G: Description of Event:

(Please provide a detailed description of the factors, including where the event 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:

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.):