Behavioral Health
Critical Incident Report

PacificSource Community Solutions

Member information

Name of member _____ Date of birth _____ Oregon Health Plan ID _____

Address _____ City _____ State _____ Zip _____

Gender identity:

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Gender nonconforming/genderqueer
- ☐ Gender fluid/not exclusively male or female
- ☐ Intersex/intergender
- ☐ Something else fits better (please specify):

_____

Race/ethnicity:

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino/a/x
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other (please specify): _____

Language(s) spoken _____ Serious and persistent mental illness: ☐ Yes ☐ No

Provider information

Prepared by (provider name and agency) _____

Clinical director/supervisor _____ Date submitted to PacificSource Community Solutions _____

Incident information

Date of incident _____ Date reported to provider _____

Location of incident _____

Incident type:

- ☐ Member attempted suicide
- ☐ Poisoning/overdose unintentional or intention unknown

Brief description of the incident.

Treatment history

Past psychiatric hospitalizations and/or residential placements (if applicable):

Facility	Dates of service	Reason

Length of treatment time at current agency _____ Date of last contact _____

Please describe last encounter with member.

Substance use disorder history

History: ☐ None ☐ Previous ☐ Current (at time of incident)

Treatment: ☐ None ☐ Previous ☐ Current (at time of incident)

Medications at the time of the incident

Please list all medications below. If more space is needed, please add a complete medication list.

Taking as prescribed? ☐ Yes ☐ No Recent changes in medications or use? ☐ Yes ☐ No

History of suicidality

Ideation/attempts: ☐ None ☐ Ideation only ☐ 1–2 attempts ☐ 3–4 attempts ☐ 5+ attempts

Time frame: ☐ Prior week ☐ Prior month ☐ 1–2 years ago ☐ 3–4 years ago ☐ 5+ years ago

If suicide risk was present prior to incident, what actions (such as safety planning or lethal means counseling) were taken?

Services provided prior to the incident

Service	Frequency scheduled	Percentage of appointments attended
Individual counseling		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Family counseling		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Group counseling		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Case management		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Medication management		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Peer-delivered services		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Other:		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%

Contributing factors

Please list any stressors (such as recent traumas and triggering events) that may have contributed to the incident.

Follow-up after the incident

Describe any medical services the member received related to the incident.

Describe the condition of the member after the incident.

What actions were taken by the provider after the incident?

Clinical director/supervisor review

Clinical director or supervisor _____ Review date _____

Please provide any additional comments related to the incident.

Please submit the following clinical documentation with this report:

- Most recent assessment(s) (such as mental health, substance use disorder, psychiatric, etc.)
- Safety plan (if applicable)
- Service notes 30 days prior to the date of Critical Incident Report submission (including nonbillable encounters)
- Suicide risk assessments (if applicable)

All submissions should be sent via encrypted email to:

Deschutes, Crook, Jefferson, Hood River, and Wasco Counties: BH.CQI@PacificSource.com

Marion and Polk Counties: BH.CQI-MPC@PacificSource.com