Reset Form

OPIOID TREATMENT PROGRAM INCIDENT REPORT

State Form 54850 (R2 / 7-14)

FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION
402 West Washington Street, Room W353
Indianapolis, IN 46204 2739
Telephone: (317) 232-7800
Secure fax: (317) 233-1986

Current date *(month, day, year)*	Date of incident *(month, day, year)*	Name of patient *(first, middle initial, last)*

Name of opioid treatment program	Name of program director	Date of patient admission *(month, day, year)*

Address of opioid treatment program *(number and street, city, state, and ZIP code)*

Type of sentinel event *(Please check appropriate box.)*

An opioid treatment program shall notify the division in the manner designated by the division within twenty-four (24) hours after an opioid treatment program is notified of the occurrence of any of the following events:

- ☐ A serious patient injury with the potential loss of functioning or the marked deterioration of a patient's condition occurring under unanticipated or unexpected circumstances.
- ☐ A chemical poisoning occurring within the opioid treatment program resulting in harm or injury to a patient or other.
- ☐ An unexplained loss or theft of a controlled substance.
- ☐ A disruption, exceeding four (4) hours, in the continued safe operation of the opioid treatment program or in the provision of patient care, caused by any of the following:
  - (A) Internal or external disasters
  - (B) Strikes by health care workers
  - (C) Unscheduled revocation of vital services
- ☐ Any fire or explosion.

If not a death skip this section.

☐ The death of either of the following
- ☐ An enrolled patient
- ☐ An individual residing with an enrolled patient if the death is related to the ingestion of opioid treatment medication

Date of birth of deceased *(month, day, year)*	Date of death of deceased *(month, day, year)*	Age of deceased	Gender of deceased ☐ Male ☐ Female

How many days / week was patient attending the OTP at time of death?	What outreach has been provided to the family of the deceased?

Is a Coroner's Report expected? *(If yes, please provide Division of Mental Health and Addiction with a copy when available.)*
☐ Yes ☐ No

What were the circumstances of the death?

Medication taken	Medication patient was taking: ☐ Methadone ☐ Buprenorphine	Dosage

Was a notification made to any federally required reporting service? ☐ Yes ☐ No	If yes, what agency?

Date of last UDS *(month, day, year)*	Results of last UDS	Describe the take-home privileges.

Are there any unaccounted for take-home medication or empty bottles? ☐ Yes ☐ No	If yes, describe what was missing.

Please provide a description and location of the incident.

What was the resolution of the incident?

Signature of opioid treatment program personnel	Date *(month, day, year)*

FOR DMHA USE ONLY

Incident follow-up, as applicable:

Date DMHA received report *(month, day, year)*	Agency submitted report in a timely manner? ☐ Yes ☐ No

Approval of assistant deputy *(if applicable)*	Date *(month, day, year)*

Approval of medical director *(if applicable)*	Date *(month, day, year)*