Iowa Department of Public Health
Critical Incident Form

Date:	Name/title of individual completing the form:
Agency name:	
Address (include City):	
Phone:	Email:
Location of incident:	

Name of patient or person involved in the incident:	
Unique Client Number:	
☐ Male ☐ Female	Age:
List any other involved party (i.e., patient, family member, visitor, staff, member, etc.):	
Specify service being provided or treatment level of care:	
Date of the incident: Time of the incident: ☐ a.m. ☐ p.m.	
The incident was: ☐ Witnessed ☐ Discovered	

Type of Incident:

☐ Death – specify:
☐ Suicide attempt
☐ Self-injury
☐ Assault/abuse of others
☐ Medication error
☐ Unauthorized departure from a 24-hour facility pursuant to a court order (AMA/ASA non committals are not required to be reported)
☐ Behavior that requires the intervention of law enforcement
☐ Behavior that results in physical injury
☐ Condition that requires emergency medical treatment
☐ Condition that requires emergency mental health treatment
☐ Other dangerous behavior
☐ Other:

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Brief description of incident:	
Follow-up actions taken by agency (i.e patient admitted to hospital, counseling/referral provided to family, revised policies/procedures):	
Resolution as a result of follow-up action:	
Signature of individual completing form:	Date:

Email to IPN@idph.iowa.gov, Attention: Critical Incident,
within 24 business hours of when the incident occurred or when the agency was informed of the incident. Retain a copy of the form in the client's file.

If this critical incident pertains to a patient related issue, please ensure this form is sent securely.