

BEHAVIORAL HEALTH ADMINISTRATION

Catonsville, MD 21228

NOTIFICATION OF SERIOUS INJURY (NOT RELATED TO RESTRAINT/SECLUSION) OR SUICIDE ATTEMPT FOR A MINOR IN A RESIDENTIAL TREATMENT CENTER

This form is to be completed when a child residing in a residential treatment center makes a suicide attempt or incurs a serious injury as defined in the 42 CFR 483.352. The report must be made by close of business the next business day after the occurrence.

“Serious injury” means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else. All serious injuries must be reported.

If a serious injury was incurred during the course of a restraint or seclusion, the form entitled “NOTIFICATION OF A SERIOUS INJURY DURING RESTRAINT OR SECLUSION FOR A CHILD IN A RESIDENTIAL TREATMENT CENTER” must be used.

Serious Injury: □ Suicide Attempt: □ (Check one or both)

Name of Residential Treatment Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_

Name of Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of injury or suicide attempt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Minor’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Jurisdiction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Admission to RTC: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nature of injury, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How injury occurred, if applicable (please attach an additional sheet if necessary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The services and programs of the Maryland Department of Health are provided on a non-discriminatory basis and in compliance with Title VI of the Civil Rights Act of 1964. Any complaints regarding alleged discrimination may be filed in writing with the Director, Behavioral Health Administration, Spring Grove Hospital Center, 55 Wade Avenue, Dix Building, Catonsville, MD 21228, and the Office of Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall West, Suite 372, Philadelphia, PA 19106-3499.

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If suicide attempted, describe method attempted and outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons Notified:

 Parent/Guardian Yes □ No □ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date and Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Referring Agency Yes □ No □ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date and Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DRM Yes □ No □ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date and Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Submitted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name and Title (Please Print)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Forward to the: Behavioral Health Administration - Office of Compliance

 55 Wade Avenue, Dix Building

 Catonsville, MD 21228

 Phone: (410) 402-8451; Fax: (410) 402-8441;

 and

 Disability Rights Maryland

 1500 Union Ave., Suite 2000

 Baltimore, MD 21211

 Phone: (410) 727-6352 or 1-800-233-7201 (only within Maryland)

 TTY number: (410) 235-5387

Fax: (410) 727-6389

**This is protected health information and must be in compliance with State and Federal privacy laws.**

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