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**NOTIFICATION OF SERIOUS INJURY OR SUICIDE**

**ATTEMPT FOR A CHILD 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 Code of Federal Regulations, Section 483 352: This form is to be completed for both restraint/seclusion and non-restraint/seclusion related injuries.

“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 some else.” All serious injuries must be reported. Occurrences must be reported no later than close of business on the next business day after the occurrence.

Serious Injury [ ]  Suicide Attempt [ ]  (Check one or both)

Serious injury during (check one) restraint [ ]  seclusion [ ]  not during seclusion/restraint [ ]

Name of Residential Treatment Center: Click or tap here to enter text.

Address: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

Name of Child: Click or tap here to enter text. Date of Injury OR Suicide Attempt: Click or tap to enter a date.

Child’s Date of Birth: Click or tap here to enter text. Child’s Home Jurisdiction: Click or tap here to enter text.

Date of Admission to RTC: Click or tap here to enter text.

Referral Agency/Source: Click or tap here to enter text.

Name of Parent/Guardian: Click or tap here to enter text.

Nature of Injury, if applicable: Click or tap here to enter text.

How Injury Occurred/Description of Incident:

Click or tap here to enter text.

|  |  |  |
| --- | --- | --- |
| Person Notified: | Name of Person Notified | Date of Notification |
| Parent/Guardian Yes [ ]  No [ ]  | Click or tap here to enter text. | Click or tap to enter a date. |
| Referring Agency Yes [ ]  No [ ]  | Click or tap here to enter text. | Click or tap to enter a date. |

Forward to the below listed agencies. Please note: this form contains PHI and cannot be disclosed unless otherwise provided by HIPAA or the MCMRA. **Use encryption to email any forms; fax if encryption is not available.**

Required Agency Notifications Date of Notification

|  |  |
| --- | --- |
| State Medicaid Agency Contact:Caroline Jones, BHA Email: cjones@maryland.gov Phone: (410) 402-8488, Fax: (410) 402-8486  | Click or tap to enter a date. |
| Secretary of Health Contact:Renee Webster, OHCQ Email: [renee.webster@maryland.gov](file:///C%3A/Users/lbosley.OAS/Downloads/renee.webster%40maryland.gov)Phone: 410-402-8116  Fax: 410-402-8167 | Click or tap to enter a date. |
| Protection and Advocacy Agency:Disability Rights Maryland Email: mhreports@disabilityrightsmd.org Phone: (410) 727-6352 ext 2504, Fax: (410) 727-6389. | Click or tap to enter a date. |

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

Name and Title (print)

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