|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Name: | |  | |  | Date of last Service:  (mm/dd/yy) | |  | | | |
| Client PSP No.: | |  | |  |  | |  | | | |
| Client DOB: | |  | |  | Date & Time of Incident:  (mm/dd/yy/h:mm) | |  | | | |
| Provider Site/RU: | |  | |  |  | |  | | | |
| Primary Clinician: | | |  |  | Location of Incident: | |  | | | |
| Primary Diagnosis: | | |  | | | | | | | |
| Has a client death occurred? | | | | | Yes | |  | NO |

If yes, please fill in the following table. If no, please skip to #7.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | | Was the client recently in an institutional in-patient facility? | | | | | | Yes |  | NO | |
| 2. | | If yes, which facility? | | | | | | | | | |
| 3. | | How soon did the client’s death occur after discharge from an institutional setting? | | | | | |  | Number of Days | | |
| 4. | | What was the length of stay prior to discharge from institutional care? | | | | | |  | Number of Days | | |
| 5. | | What type of out-patient service was provided? | | | | | |  | | | |
|  | |  | | | | | | | | | |
| 6. PLEASE INDICATE CAUSE OF DEATH: | | | | | | | | | | |
|  | Suicide | | |  |  | Natural Causes | | | | |
|  | Homicide | | |  |  | Other/Please explain: |  | | | |
|  | Secondary to Medical Condition: | |  | | |

1. Details of Incident:

1. Injuries/Damages incurred:

1. Please list existing medical conditions:

1. Was an internal review of the case conducted by the provider site? YES NO *If yes, please attach any associated report*
2. Please attach and list other mandated reports made to other agencies:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | |
| Agency QA Staff to contact regarding report |  | Contact Phone Number | |
|  |  |  |
| Name of person completing form (*if different than above)* |  | Contact Phone Number |
|  |  |  | |
| Agency Name and Address |  | mm/dd/yy  Date Form Completed | |

Please return completed form to:

|  |  |  |
| --- | --- | --- |
| Secure Email to:  QAOffice@acbhcs.org | FAX: QA Administrator  510.639.1346 | Mail: ACBHCS- QA Administrator  2000 Embarcadero Cove, Ste 400  Oakland, CA 94606 |