|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 Administrator510.639.1346 | Mail: ACBHCS- QA Administrator2000 Embarcadero Cove, Ste 400Oakland, CA 94606 |