Quality Assurance Office
Unusual Occurrence/Death Reporting Form
Confidential Quality Assurance Document

Client Name: ____________________
Client PSP No.: ____________________
Client DOB: ____________________
Provider Site/RU: ____________________
Primary Clinician: ____________________
Date of last Service: (mm/dd/yy) ____________________
Date & Time of Incident: (mm/dd/yy/h:mm) ____________________
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**
   - ☐ **Homicide**
   - ☐ **Secondary to Medical Condition:** ____________
   - ☐ **Natural Causes**
   - ☐ **Other/Please explain:** ____________
7. **Details of Incident:** ____________________
8. **Injuries/Damages incurred:** ____________________
9. **Please list existing medical conditions:** ____________________
10. **Was an internal review of the case conducted by the provider site?** ☐**YES** ☐**NO** *If yes, please attach any associated report*
11. **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