|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Client Name:  |       | Client DOB: |       | Date of Last Service: |        |
| Client PSP No.:  |       | Provider Site/RU:  |       | Date & Time of Incident: |       |
| Primary Clinician: |       | Location of Incident: |       |
| Primary Diagnosis: |       |
| Known Allergies:  |       |
| Current Medication(s): Please include Prescriber; Dose/frequency; Initial prescription date & Refills left: |       |

|  |  |  |
| --- | --- | --- |
|  | What type of Services were provided by your agency? | [ ]  MH or [ ]  SUD Services |
|  | Description of Services: |       |
|  | Has a client death occurred? | [ ] Yes [ ]  No If no, please skip to #5 |
|  | PLEASE INDICATE CAUSE OF DEATH: |  |
| [ ]  Suicide | [ ]  Natural Causes | [ ]  Homicide | [ ]  Accidental |
| [ ]  Secondary to Medical Condition:       | [ ] Other/Unknown:      |
| 1. Narrative 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*
 |
| 1. 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 |