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| --- | --- | --- | --- | --- | --- |
| 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: | | | | | | | | | | | |

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| 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 |