alameda county behavioral health
SERVICES FOR MENTAL HEALTH & SUBSTANCE USE DISORDERS

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

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:

1. **What type of Services were provided by your agency?** ☐ **MH or** ☐ **SUD Services**
2. **Description of Services:**

3. **Has a client death occurred?** ☐**Yes** ☐ **No** **If no, please skip to #5**
4. **PLEASE INDICATE CAUSE OF DEATH:**
   ☐ **Suicide** ☐ **Natural Causes** ☐ **Homicide** ☐ **Accidental**
   ☐ **Secondary to Medical Condition:** ☐**Other/Unknown:**

5. **Narrative of Incident:**

6. **Injuries/Damages incurred:**

7. **Please list existing medical conditions:**

8. **Was an internal review of the case conducted by the provider site?** ☐**YES** ☐**NO**
   If yes, please attach any associated report

9. **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