Behavioral Health Department
Alameda County Health

Quality Assurance Office

Unusual Occurrence Notification (UON) Form

Confidential Quality Assurance Document

Client Information		
Client name:	Client Date of Birth:	Client ACBH No:

Provider Information	
Name of reporting agency:	Reporting agency Reporting Unit (RU):
Address of reporting agency:	
Type of service provided by your agency: ☐ MH ☐ SUD	Date of last service:
Level of care and intensity of services provided to client by your agency (e.g. Monthly Outpatient, Weekly Intensive Outpatient):	
Names of other agencies providing services to client (if known):	

Occurrence Details	
Date and time of occurrence:	Location of occurrence:
Has a client death occurred? ☐ Yes ☐ No	
If YES, select suspected cause of death: ☐ Suicide ☐ Medical Illness ☐ Homicide ☐ Accidental ☐ Other/unknown If NO, please indicate UO Reason: ☐ Harm to Self ☐ Medical Hospitalization ☐ Harm to Others ☐ Client Violation of Facility Rules ☐ Other If Other, please note reason here:	
Narrative of occurrence/incident:	
Client's primary diagnosis:	
Was an internal review of the case conducted by your agency? ☐ Yes ☐ No *If yes, please attach any associated reports*	
Please list and attach other mandated reports made to other agencies:	
Name and title of person completing this report:	Phone number:
Name and title of agency contact for questions related to this report (if different):	Phone number:
Date form is completed (mm/dd/yy):	

Please return completed form using encrypted email to: QAOffice@acgov.org, or by fax to: QA Administrator, 510-639-1346; or mail to: ACBHD, ACBHD Quality Assurance, 2000 Embarcadero Cove, Ste 400, Oakland, CA 94606