

Partners in Recovery

PM FORM 7.4.1 INCIDENT/ACCIDENT/DEATH REPORT FORM

INSTRUCTIONS:

1. Complete **ALL** sections of this form. Information provided must be either typed or printed.
2. Incidents, accidents and deaths occurring in facilities licensed by the ADHS Office of Behavioral Health Licensure (OBHL) must be verbally reported to OBHL (602-364-2595) within 24 hours and reported in writing to OBHL (FAX 602-364-4801) within 5 working days.
3. Incidents, accidents and deaths must be reported in writing to the TRBHA within 48 hours.
4. **Please fax to Magellan Health Services at 1-800-424-4259 or 1-888-290-1282**

Behavioral Health Facility Name: _____	Behavioral Health License#: _____	Subclass: _____	Tracking ID#: _____
Behavioral Health Facility Address & Phone #: _____			
TYPE OF REPORT: Check all that apply			
<input type="checkbox"/> Death (All Must Be Reported) <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide (victim) <input type="checkbox"/> Accidental death <input type="checkbox"/> Natural <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown			
THE FOLLOWING ARE REPORTED ONLY FOR THOSE INCIDENTS OCCURRING ON PREMISES OR DURING A LICENSEE SPONSORED ACTIVITY OFF PREMISES, INCLUDING A LICENSED SPONSORED PREVENTION ACTIVITY, IN WHICH CASE REPORTING IS REQUIRED FOR NON-ENROLLED PERSONS: <input type="checkbox"/> Medication Error(s) (requiring medical services) <input type="checkbox"/> Adverse Reaction to Medication (requiring medical services) <input type="checkbox"/> Physical Abuse/Allegation <input type="checkbox"/> Sexual Abuse/Allegation <input type="checkbox"/> Suicide Attempt (requiring medical services) <input type="checkbox"/> Self-Inflicted Injury (requiring medical services) <input type="checkbox"/> Physical Injury (requiring medical services) <input type="checkbox"/> Food Poisoning (requiring medical services) <input type="checkbox"/> Physical injury that occurred as the result of a personal or mechanical restraint.	THE FOLLOWING ARE REPORTED REGARDLESS OF WHERE THE MEMBER RIGHTS VIOLATION/ALLEGATION OCCURRED: <input type="checkbox"/> <u>Member Rights Violation/Allegation (specify below):</u> <input type="checkbox"/> Discrimination <input type="checkbox"/> Abuse (according to R9-20-203) <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation <input type="checkbox"/> Coercion <input type="checkbox"/> Manipulation <input type="checkbox"/> Retaliation for submitting complaint to authorities <input type="checkbox"/> Threat of discharge/transfer for punishment <input type="checkbox"/> Treatment involving denial of food <input type="checkbox"/> Treatment involving denial of opportunity to sleep <input type="checkbox"/> Treatment involving denial of opportunity to use toilet <input type="checkbox"/> Use of restraint or seclusion as retaliation <input type="checkbox"/> Abuse or neglect reported to Adult Protective Services <input type="checkbox"/> Abuse of neglect reported to Child Protective Services		
<input type="checkbox"/> Unauthorized Absence from Residential Agency/ Inpatient Treatment Program/Level IV Transitional Agency or Adult Therapeutic Foster Home. <input type="checkbox"/> Suspected or alleged criminal activity either occurring on the premises or off the premises during a licensee-sponsored activity.	<input type="checkbox"/> Discovery that a client, staff member, or employee has a communicable disease (listed in R9-6-202) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Additional reports required by the T/RBHA or Arizona State Hospital:		
ENROLLED MEMBER INVOLVED IN INCIDENT:			
Name: _____		CIS ID#: _____	
Address: _____		Phone: _____	
Age: _____	DOB: _____	Gender: Female <input type="checkbox"/> Male <input type="checkbox"/>	
Check All That Apply:	Title XIX <input type="checkbox"/>	Title XXI <input type="checkbox"/>	Non Title XIX/XXI <input type="checkbox"/>
	SMI <input type="checkbox"/>	SMI/Special Assist. <input type="checkbox"/>	SA/GMH <input type="checkbox"/>
Current Diagnosis: Axis I _____ Axis II _____ Axis III _____		Non-enrolled <input type="checkbox"/>	
Date of Last Visit to Psychiatrist: _____		Child <input type="checkbox"/>	
		Psychiatrist Name: _____	

Partners in Recovery

Date of Last Visit to Nurse: _____ Date of Last Visit to Clinical Liaison: _____

Enrolled Member Name: _____

INCIDENT DETAILS:

Date & Time of Incident: _____
Address & Location: _____
Provider Name: _____
Provider Address: _____
Program Admission Date: _____

Name of Clinical Liaison & Phone Number: _____

INDIVIDUALS WHO OBSERVED INCIDENT (including staff and witnesses):

Name: _____ Relationship to enrolled person: _____
Address: _____ Phone#: _____

Name: _____ Relationship to enrolled person: _____
Address: _____ Phone#: _____

Name: _____ Relationship to enrolled person: _____
Address: _____ Phone #: _____

DESCRIPTION OF INCIDENT

Describe the events leading up to and including the incident:

Describe the person's physical and behavioral health condition before the incident:

Partners in Recovery

Describe the person's physical and behavioral health condition after the incident:

Enrolled Member Name: _____

Document any actions taken and/or recommendations for action to prevent a similar incident from occurring in the future:

Preparer's Name & Title:

Phone#:

Preparer's Signature:

Date Signed:

COMPLETE THIS SECTION FOR ALL INCIDENTS/ACCIDENTS REQUIRING MEDICAL SERVICES

Who provided immediate attention:

Who provided medical services:

Date and time of medical services:

Emergency Room (ER) services:

If YES, name of ER:

YES

NO

Name of ER: _____

Hospital admission:

If YES, name of hospital and date of admission:

YES

NO

Name of hospital: _____

Attending physician: _____

Results of medical services:

Medications: _____

Date of admission: _____

Reported to:

APS CPS N/A

Partners in Recovery

CLINICAL DIRECTOR'S OR DESIGNEE'S REVIEW OF INCIDENT: Review all relevant information and documentation in the member's record. Ascertain objectively what occurred and document any actions you have taken and/or recommendations that you have made. **NOTE:** This section **MUST** be completed and signed in order for the incident to be processed.

CLINICAL DIRECTOR OR DESIGNEE'S NAME & CREDENTIAL & TITLE:

PHONE#:

CLINICAL DIRECTOR OR DESIGNEE'S SIGNATURE

DATE SIGNED: