



Unusual Occurrence Notification Mental Health Services

CONFIDENTIAL - DO NOT PLACE IN MEDICAL RECORD

Please send completed form to: Behavioral Health Administration/Quality Assurance Unit 1340 Arnold Drive Ste. 200, Martinez, CA 94553 Fax: 925-957-5208	<u>ADMIN USE ONLY</u>	
	<u>Log</u>	<u>Date</u>
	# _____	Recd _____

Occurrence Type

<input type="checkbox"/> Assault-Consumer	<input type="checkbox"/> Death-Homicide	<input type="checkbox"/> Injury	<input type="checkbox"/> Property Damage	<input type="checkbox"/> Theft
<input type="checkbox"/> Assault-Staff	<input type="checkbox"/> Death-Suicide	<input type="checkbox"/> Linguistic Service	<input type="checkbox"/> Rx Error/Issue	<input type="checkbox"/> Threat
<input type="checkbox"/> Death-Accident	<input type="checkbox"/> Death-Unknown	<input type="checkbox"/> Site/Vehicle Issue	<input type="checkbox"/> Severe Agitation	<input type="checkbox"/> Violence
<input type="checkbox"/> Death-Natural	<input type="checkbox"/> HIPAA/Confidentiality	<input type="checkbox"/> Medical	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Other

Date of Occurrence: _____ Time _____ Name of Individual: _____

Consumer Visitor Staff MRN (if applicable): _____

Mental Health site where consumer is followed: _____

County Clinic/Program Contract Agency Network Provider Other

Location of Occurrence

<input type="checkbox"/> Apartment	<input type="checkbox"/> Home	<input type="checkbox"/> Parking lot	<input type="checkbox"/> Vehicle
<input type="checkbox"/> Board and Care	<input type="checkbox"/> Hospital	<input type="checkbox"/> Shelter	<input type="checkbox"/> Other
<input type="checkbox"/> Clinic	<input type="checkbox"/> IMD	<input type="checkbox"/> Street	<input type="checkbox"/> Unknown

Description of Occurrence

Other Persons with Knowledge of Occurrence

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Printed name of staff completing form Phone number

Signature of staff completing form Date

Program Manager/Supervisor Action taken: _____

Program Manager/Supervisor Signature Date

Program Chief followup action requested: _____

Program Chief Signature Date