

**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, including those occurring during a T/RBHA or provider sponsored activity affecting non-enrolled persons must be reported in writing to the TRBHA within **48 hours**, or two business days.
4. A verbal report should be made to the case manager and parent/guardian (TSS case worker) within 24 hours.
5. Email to: daarntsen@grhc.org and ealeva@grhc.org via Zixmail <https://web1.zixmail.net/s/login?b=grhc>
Gila River BHS QI Dept. Phone: (520) 550-6207 Fax: (520) 550-6040

Behavioral Health Facility Name:	Behavioral Health License#:	Subclass:	Tracking ID#:
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Behavioral Health Facility Address & Phone #:

TYPE OF REPORT: Check all that apply

Death (All Must Be Reported)

- Suicide
- Homicide (victim)
- Accident
- Natural
- Other (specify): _____
- Unknown

THE FOLLOWING ARE REPORTED ONLY FOR 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:

- Medication Error(s) (requiring medical services)
- Adverse Reaction to Medication (requiring medical services)
- Physical Abuse/Allegation
- Sexual Abuse/Allegation
- Suicide Attempt (requiring medical services)
- Self-Inflicted Injury (requiring medical services)
- Physical Injury (requiring medical services)
- Food Poisoning (requiring medical services)
- Physical injury that occurred as the result of a personal or mechanical restraint.

THE FOLLOWING VIOLATIONS, RESULTING FROM PROVIDER STAFF ACTION OR OMISSION, ARE REPORTED REGARDLESS IF THEY OCCURRED IN AN OBHL LICENSED FACILITY, OR NOT:

- Member Rights Violation/Allegation (specify below):**
 - Discrimination
 - Abuse (according to R9-20-203)
 - Neglect
 - Exploitation
 - Coercion
 - Manipulation
 - Retaliation for submitting complaint to authorities
 - Threat of discharge/transfer for punishment
 - Treatment involving denial of food
 - Treatment involving denial of opportunity to sleep
 - Treatment involving denial of opportunity to use toilet
 - Use of restraint or seclusion as retaliation
- APS OR CPS Referral was made:**
 - Abuse or neglect reported to Adult Protective Services
 - Abuse or neglect reported to Child Protective Services

- Unauthorized Absence from Residential Agency/ Inpatient Treatment Program/Level IV Transitional Agency or Adult Therapeutic Foster Home.**
- Suspected or alleged criminal activity either occurring on the premises or off the premises during a licensee-sponsored activity.**

- Discovery that a client, staff member, or employee has a communicable disease (listed in R9-6-202)**
- Other (specify):** _____
- 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

Male

Check All That Apply: Title XIX Title XXI Non Title XIX/XXI Non enrolled

SMI SMI/Special Assist. SA/GMH Child

Current Diagnosis: Axis I _____ Axis II _____ Axis III _____

Date of Last Visit to Psychiatrist: _____ Psychiatrist Name: _____

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

Name of Enrolled/Non-enrolled person: _____

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:

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

Name of Enrolled/Non-enrolled person: _____

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: _____

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: