

**PM FORM 7.4.1  
INCIDENT/ACCIDENT/DEATH REPORT FORM DRAFT**

**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 prevention activity affecting non-enrolled persons must be reported in writing to the TRBHA within 48 hours, or two business days.
4. FAX to NARBHA Director of Quality Management 928-774-5665.

<b>Behavioral Health Facility Name:</b>	<b>Behavioral Health License#:</b>	<b>Subclass:</b>	<b>Tracking ID#:</b>
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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 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:**

- 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
  - 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 of neglect reported to Child Protective Services

- Unauthorized Absence from Residential Agency/ Inpatient Treatment Program/Level IV Transitional Agency who are under the age of 18; 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 OR NON-ENROLLED BEHAVIORAL HEALTH RECIPIENT 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"/> Non-enrolled <input type="checkbox"/>



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:	<input type="checkbox"/> YES <input type="checkbox"/> NO    Name of ER: _____
Hospital admission: If YES, name of hospital and date of admission:	<input type="checkbox"/> YES <input type="checkbox"/> 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.

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

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PHONE#:

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CLINICAL DIRECTOR OR DESIGNEE'S SIGNATURE

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DATE SIGNED: