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 prevention activity affecting non-enrolled persons must be reported in writing to the TRBHA within 48 hours, or two business days.
4. **You may fax the form to:**
   Magellan at 1-888-290-1282 or 1-888-290-1285, Attention: QI Dept.
   Or, you may mail the form to:
   Magellan Health Services of Arizona
   Attention: QI Dept.
   P.O. Box 68110
   Phoenix, AZ 85082-8110
   Or, you may email the form to: QIRisk@MagellanHealth.com

Behavioral Health Facility Name:	Behavioral Health License#:	Subclass:	Tracking ID#:

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 LICENSEE 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:**

Name or Enrolled/Non-enrolled Person: ______________________________

ENROLLED MEMBER OR NON-ENROLLED BEHAVIORAL HEALTH RECIPIENT 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: ____________

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/non-enrolled person: ____________
Address: ____________________ Phone#: ____________

Name: ____________________ Relationship to enrolled/non-enrolled person: ____________
Address: ____________________ Phone#: ____________

Name: ____________________ Relationship to enrolled/non-enrolled person: ____________
Address: ____________________ Phone #: ____________

Name or Enrolled/Non-enrolled Person: ______________________________

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:

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: **Results of medical services:**	☐ **YES** ☐ **NO** **Name of hospital:** ______________________ **Attending physician:** ______________________ **Medications:** **Date of admission:** ______________________

Last Revision Date: 11/26/2009
Effective Date: 01/15/2010
Magellan Revision Date: 06/21/2010

Name or Enrolled/Non-enrolled Person: ______________________________

<u>CLINICAL DIRECTOR'S OR DESIGNEE'S REVIEW OF INCIDENT</u>: 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:**