Please type information, print, and send via secure email

Adverse Incident Report for ALL LOC

INCLUDING: FFS Provider Type 73 and 74

Health Plans: □ **MBHP** □ **Tufts** □ **HNE** □ **Fallon** □ **BMCHP** □ **AHP** □ **FFS** □ **CP:**

Member name: _____

Gender: □ Male □ Female □ Transgender **DOB:** _____ **Age**: _____

Date and time of incident: mm/dd/yyyy _____

Date and time of discovery: mm/dd/yyyy _____

Plan Incident Code for member _____

Facility: _____ City: _____ **Provider number**: _____

□ **24-hour facility** □ **Non 24-hour facility**

Level of care: _____ **Diagnosis:** _____

Type of incident: _____

State agency involvement: □ DMH □ DCF □ DYS □ DPPC □ DDS □ other

Restraints used? □ None □ Mechanical □ Chemical □ Physical □ Multiple □ Seclusion: _____

Describe incident. If AWA, please include search, notification, and commitment status:

_____

_____

_____

_____

_____

_____

_____

Describe immediate response to the incident:

_____

_____

_____

_____

Please check if recommended:
Internal investigation □ Policy and procedure review □ Staff training □ Disciplinary action to staff □

Please check if additional information is attached.

Person reporting (and title): _____ **Telephone #:** _____

Signature: _____ **Date:** _____

Date Revised: 08/10/.2020