

**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. **[T/RBHA insert specific reporting contact information, including phone and fax number]**

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

**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 ARE REPORTED REGARDLESS OF WHERE THE MEMBER RIGHTS VIOLATION/ALLEGATION OCCURRED:**

- 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
- 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 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"/>
	SMI <input type="checkbox"/> SMI/Special Assist. <input type="checkbox"/> SA/GMH <input type="checkbox"/> Child <input type="checkbox"/>



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

Enrolled Member Name: \_\_\_\_\_

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: