Quality Assurance Office
Unusual Occurrence/Death Reporting Form
Confidential Quality Assurance Document

Client Name: ____________ **Date of last Service:** (mm/dd/yy) ____________
Client PSP No.: ____________
Client DOB: ____________ **Date & Time of Incident:** (mm/dd/yy/h:mm) ____________
Provider Site/RU: ____________
Primary Clinician: ____________ **Location of Incident:** ____________
Primary Diagnosis: ____________

Has a client death occurred? ☐ Yes ☐ NO

If yes, please fill in the following table. If no, please skip to #7.

1. **Was the client recently in an institutional in-patient facility?** ☐ Yes ☐ NO
2. **If yes, which facility?**
3. **How soon did the client's death occur after discharge from an institutional setting?** ________ **Number of Days**
4. **What was the length of stay prior to discharge from institutional care?** ________ **Number of Days**
5. **What type of out-patient service was provided?**

6. **PLEASE INDICATE CAUSE OF DEATH:**

☐ **Suicide**
☐ **Homicide**
☐ **Secondary to Medical Condition:** ____________
☐ **Natural Causes**
☐ **Other/Please explain:** ____________

7. **Details of Incident:**

8. **Injuries/Damages incurred:**

9. **Please list existing medical conditions:**

10. **Was an internal review of the case conducted by the provider site?** ☐ **YES** ☐ **NO** *If yes, please attach any associated report*

11. **Please attach and list other mandated reports made to other agencies:** _____

____
Agency QA Staff to contact regarding report

____
Contact Phone Number

____
Name of person completing form (***if different than above)***

____
Contact Phone Number

____
Agency Name and Address

____
mm/dd/yy
Date Form Completed

Please return completed form to:

Secure Email to:
QAOffice@acbhcs.org

FAX: QA Administrator
510.639.1346

Mail: ACBHCS- QA Administrator
2000 Embarcadero Cove, Ste 400
Oakland, CA 94606