

Client Information

Client name:	Client Date of Birth:	Client ACBH No:
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Provider Information

Name of reporting agency:	Reporting agency Reporting Unit (RU):
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Address of reporting agency:

Type of service provided by your agency: <input type="checkbox"/> MH <input type="checkbox"/> SUD	Date of last service:
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Level of care and intensity of services provided to client by your agency (e.g. Monthly Outpatient, Weekly Intensive Outpatient):

Names of other agencies providing services to client (if known):

Occurrence Details

Date and time of occurrence:	Location of occurrence:
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Has a client death occurred? Yes No

If YES, select suspected cause of death: Suicide Medical Illness Homicide Accidental Other/unknown

If NO, please indicate UO Reason: Harm to Self Medical Hospitalization Harm to Others Client Violation of Facility Rules Other

If Other, please note reason here:

Narrative of occurrence/incident:

Client's primary diagnosis:

Was an internal review of the case conducted by your agency? Yes No
If yes, please attach any associated reports

Please list and attach other mandated reports made to other agencies:

Name and title of person completing this report:	Phone number:
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Name and title of agency contact for questions related to this report (if different):	Phone number:
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Date form is completed (mm/dd/yy):

Please return completed form using encrypted email to: QAOffice@acgov.org, or by fax to: QA Administrator, 510-639-1346; or mail to: ACBH, QA Administrator, 2000 Embarcadero Cover, Ste 400, Oakland, CA 94606