Please type information, print, and send via secure email

Adverse Incident Report for ALL LOC

INCLUDING: FFS Provider Type 73 and 74

Member name: _____ **MassHealth ID**: _____

Health Plans: ☐ **MBHP,** ☐ **Tufts,** ☐ **HNE,** ☐ **Fallon,** ☐ **BMCHP,** ☐ **AHP,** ☐ **FFS,** ☐ **OTHER**

CP: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other _____ **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:** _____

You can submit this form via secure email to OBH.mailbox@mass.gov

Date Revised: 08/10/2020