APPENDIX F-1

INCIDENT REPORT FORM

Please send by secure email to MassHealth Office of Behavioral Health

Adverse Incident Report

Notifications: ☐ (Contractor's Name) ☐ DMH ☐ DCF ☐ DYS ☐ DPPC ☐ DDS ☐ Other

Client: **Social Security** #:

☐ **M** ☐ **F** **DOB**: **Age**:

Facility: **Unit**: **City**:

☐ **24-hour facility** ☐ **Non 24-hour facility**

Date and Time of Incident: mm/dd/yyyy@hh:mm

Date and Time of Discovery: mm/dd/yyyy@hh:mm

Type of Incident:

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

Describe Immediate Response to the Incident:

Restraints Used? ☐ None ☐ Mechanical ☐ Chemical ☐ Physical **Time in Restraints**:

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: **Telephone #**:

Signature: **Date:**

Date Revised: 11/23/2010