



**Behavioral Health  
 ADVERSE OCCURRENCE REPORT**

Facility/Provider Name:  Information of Person submitting report: Name:  Title:  Phone:  Email:  Date Submitted to BCBST:	Member Name:  Member ID:  Member SSN:  Member Address:  DOB:  Member's Health Plan: <input type="checkbox"/> CoverKids <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> BCBST <input type="checkbox"/> BlueCare <input type="checkbox"/> Other:
--	---

Persons Involved (Check all that apply) <input type="checkbox"/> Clients <input type="checkbox"/> Staff <input type="checkbox"/> Persons Not Associated with Facility <input type="checkbox"/> Other: _____	Date of Incident: _____ Time of Incident: _____  Location of Incident: _____  Member's Related Current Level of Care (LOC), check one: <input type="checkbox"/> Inpatient Acute Care <input type="checkbox"/> Inpatient Sub-acute Care <input type="checkbox"/> Residential Treatment (RTC) <input type="checkbox"/> Partial Hospitalization Program (PHP) <input type="checkbox"/> Crisis Stabilization Unit (CSU) <input type="checkbox"/> Outpatient Services (please specify): _____
---	---

Type of Behavioral Health Adverse Occurrence (Check One) <input type="checkbox"/> Suicide Death <input type="checkbox"/> Non-Suicide Death, cause known <input type="checkbox"/> Death-Cause Unknown <input type="checkbox"/> Homicide, resulting in fatality <input type="checkbox"/> Homicide Attempt w/significant medical intervention* <input type="checkbox"/> Suicide Attempt w/significant medical intervention* <input type="checkbox"/> Allegation of Abuse/Neglect-Including Peer to Peer (Physical, Sexual, Verbal)	<input type="checkbox"/> Medical Emergency (i.e., heart attack, medically unstable, etc.) <input type="checkbox"/> Accidental Injury w/significant medical intervention* <input type="checkbox"/> Use of Restraints/Seclusion (Physical, Chemical, Mechanical) requiring significant medical intervention* <input type="checkbox"/> Treatment Complications (medications errors and adverse medication reaction) requiring significant medical intervention* <input type="checkbox"/> Elopement (Specific to Inpatient and Residential services only, as related to minors or involuntary admits for adults ) <small>*Significant Medical Intervention: Requiring an ER visit or inpatient hospital stay</small>
--	---

Summary of Adverse Occurrence: (Be specific, precise and as detailed as possible)

Summary of Action Taken by Facility/Provider: <input type="checkbox"/> Notified 911 <input type="checkbox"/> Taken to Physician <input type="checkbox"/> Taken to Hospital <input type="checkbox"/> Notified Fire Department <input type="checkbox"/> Notified Police <input type="checkbox"/> Notified Mental Health Case Manager	<input type="checkbox"/> Notified Parents or Next of Kin <input type="checkbox"/> Staff Debriefing/Training <input type="checkbox"/> Reported to DHS _____ (Date) <input type="checkbox"/> Reported to DCS _____ (Date) <input type="checkbox"/> Other (Specify) _____
--	--

**INSTRUCTIONS:** Please fax completed form to BHO Quality Mgmt. Dept. at: **1-866-259-0203** within 24 hours of occurrence.