MENTAL HEALTH SERVICES

Unusual Occurrence Notification
Mental Health Services

CONFIDENTIAL - DO NOT PLACE IN MEDICAL RECORD

Please send completed form to: Behavioral Health Administration/Quality Assurance Unit 1340 Arnold Drive Ste. 200, Martinez, CA 94553 Fax: 925-957-5208	ADMIN USE ONLY Log # __________ Date Recd __________

Occurrence Type

☐ Assault-Consumer	☐ Death-Homicide	☐ Injury	☐ Property Damage	☐ Theft
☐ Assault-Staff	☐ Death-Suicide	☐ Linguistic Service	☐ Rx Error/Issue	☐ Threat
☐ Death-Accident	☐ Death-Unknown	☐ Site/Vehicle Issue	☐ Severe Agitation	☐ Violence
☐ Death-Natural	☐ HIPAA/Confidentiality	☐ Medical	☐ Suicide Attempt	☐ Other

Date of Occurrence: ____________ Time __________ Name of Individual: ______________________________

☐ Consumer ☐ Visitor ☐ Staff MRN (if applicable): ______________________________

Mental Health site where consumer is followed: ______________________________

☐ County Clinic/Program ☐ Contract Agency ☐ Network Provider ☐ Other

Location of Occurrence

☐ Apartment	☐ Home	☐ Parking lot	☐ Vehicle
☐ Board and Care	☐ Hospital	☐ Shelter	☐ Other
☐ Clinic	☐ IMD	☐ Street	☐ Unknown

Description of Occurrence

Other Persons with Knowledge of Occurrence

Name: ______________________________ Phone number: ____________________

Name: ______________________________ Phone number: ____________________

______________________________ ____________________
Printed name of staff completing form **Phone number**

______________________________ ____________________
Signature of staff completing form **Date**

Program Manager/Supervisor Action taken: ______________________________

______________________________ ____________________
Program Manager/Supervisor Signature **Date**

Program Chief followup action requested: ______________________________

______________________________ ____________________
Program Chief Signature **Date**