

BEHAVIORAL HEALTH OUTPATIENT INCIDENT REPORT

**FORWARD COMPLETED OUTPATIENT INCIDENT REPORTS VIA
INTER-OFFICE MAIL TO: QST, HEALTH CAMPUS, 2nd FLOOR or
ENCRYPTED to BH.Incidentreport@co.slo.ca.us
via Fax (805)788-2011**

office use

REPORT DATE:	NAME OF STAFF COMPLETING REPORT:
--------------	----------------------------------

CLIENT'S NAME:	CLIENT'S MEDICAL RECORD #
----------------	---------------------------

CLIENTS CLINIC LOCATION (site):

☐ DRUG AND ALCOHOL	☐ MENTAL HEALTH	☐ OTHER
---	--	--------------------------------

DATE OF INCIDENT:	TIME OF INCIDENT:	LOCATION OF INCIDENT:
-------------------	-------------------	-----------------------

TYPE OF INCIDENT:

☐	BREACH OF PROTECTED HEALTH INFORMATION (PHI) - REQUIRES IMMEDIATE NOTIFICATION: BH.Compliance@co.slo.ca.us OR 805-781-4788
☐	SUICIDE ATTEMPT
☐	DEATH
☐	TARASOFF
☐	EMS/PD CALLED
☐	CRISIS/MHET
☐	INJURY/ACCIDENT
☐	CLIENT MEDICATION ERROR
☐	ASSAULT/SAFETY ISSUES
☐	OTHER :

OTHER STAFF INVOLVED/WITNESS:

DESCRIPTION OF INCIDENT (USE PAGE 3 IF MORE SPACE IS NEEDED)

SIGNATURE OF STAFF COMPLETING FORM:	DATE
-------------------------------------	------

SUPERVISOR'S COMMENTS AND RECOMMENDATIONS:

SUPERVISOR PRINTED NAME:	
SUPERVISOR SIGNATURE:	DATE:
DIVISION MANAGER'S SIGNATURE	DATE:
DIVISION MANAGER'S INITIALS (CASES INVOLVING DEATH)	DATE:

QST INCIDENT REPORT REVIEW COMMITTEE COMMENTS AND RECOMMENDATIONS:

[illegible]

COMPLIANCE OFFICER COMMENTS AND RECOMMENDATIONS (FOR BREACH):
--

[illegible]Page 2 of ____

[illegible]