# Adverse Incident Reporting Form

This form **must** be faxed to the appropriate health plan of the member addressed below **within 24 hours** of the incident occurrence.
**Please fax to 860-262-9174**

| | |
|---|---|
| **Member Name:** | **Diagnosis:** |
| **Member Number:** | **Provider Level of care:** |
| **Member Date of Birth:** | **Incident Location:** |
| **Gender :** | **Date and Time of Incident:** |
| **Legal Status:** | **Date Form Completed:** |

**Check any of the following categories that were involved:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Death | ☐ | Abuse | ☐ | Seclusion |
| ☐ | Attempted Suicide | ☐ | Neglect | ☐ | Restraint (Physical/Mechanical, Chemical) |
| ☐ | Significant Medication Error | ☐ | Exploitation | ☐ | Other (please explain) |
| ☐ | Need for Emergency Services | ☐ | Extortion | | |
| ☐ | Elopement | ☐ | Injury/illness (Beyond First Aid) | | |

**Description of Event: (including specifics on incident, using as many pages as necessary, numbering, dating, & signing each)**

**Action taken to ensure safety of all involved: (including debriefing efforts and steps to avoid similar future events)**

| | | |
|---|---|---|
| ☐ Yes ☐ No | Parent/Guardian notified? | Date/Person notified: |
| ☐ Yes ☐ No | Law enforcement/Protective services notified(if applicable)? | If yes, agency and contact information: |
| ☐ Yes ☐ No | Member seen by psychiatrist, physician or nurse after incident? | If yes, treatment: |

**Signature:** ______________________________ **Date:** ________________________

**Print Name:** ______________________________

**Provider:** ______________________________

**Email/Phone No.:** ______________________________

**Version: December 2015**