

Please type the information, print, and fax within 24 hours of the incident to (617) 350-1981.

**Massachusetts Behavioral Health Partnership
Adverse Incident Report**

State agency involvement: MBHP DMH DCF DYS DPPC DDS Other

Member name: _____ newMMIS number: _____

Social Security #: _____

Gender: Male Female DOB: _____ Age: _____

Facility: _____ City: _____ Provider number: _____

24-hour facility Non 24-hour facility

Level of care: _____ Diagnosis: _____

Date and time of incident: mm/dd/yyyy@hh:mm

Date and time of discovery: mm/dd/yyyy@hh:mm

Type of incident: _____

Describe the incident. If Absence Without Authorization (AWA), please include search, notification, and commitment status.

Describe the 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 (and title): _____ Telephone #: _____

Signature: _____ Date: _____