City and County of San Francisco Department of Public Health
COMMUNITY BEHAVIORAL HEALTH SERVICES
Adult and Older Adult Services

☐ Update, Close & File
☐ File in Waiting for C.R.

Incident and Quality of Care Report

Print Client's Full Name _____ BIS# | | | | | | | | | |

Names of others involved in incident_____

Date of incident_____Location of incident_____

Name of Agency/Program where client has a care manager: _____
(if applicable) (PRINT, no Initials)

Name and Title of person reporting incident_____

Name of reporting agency_____Date of reporting_____
(PRINT, no Initials)

☐ **Incident resulted in a referral for medical attention.**
☐ **Incident resulted in a 5150.**
} **If either of these, describe on back.**

Then, please check one category that best describes the incident and describe on back.

Violent Behavior
- ❑ Verbally or physically threatening behavior on part of a client (includes **Tarasoff**)
- ❑ Assault or physical altercation between clients
- ❑ Assault by a client on a staff member
- ❑ Damage to property as a result of client behavior
- ❑ Alleged homicide
- ❑ Other violent behavior

❑ **Client Injury, Accident, or Acute Medical Problem**

❑ **Alleged unprofessional/unethical conduct on the part of a provider** (i.e., inappropriate verbal, physical, sexual, social, business contact)

❑ **Client's Suicide Attempt**

Client Death
- ❑ Unexpected - resulting from medical problems
- ❑ Expected - resulting from medical problems (client had a known life-threatening illness)
- ❑ Result of complications of substance abuse
- ❑ Accidental death/fatal injury
- ❑ Suicide
- ❑ Alleged homicide
- ❑ Unknown cause

Medication Issue
- ❑ Client was allegedly administered wrong medicine
- ❑ Client was allegedly administered wrong dose
- ❑ There was an alleged issue with the timeliness of obtaining or the administration of a client's medication
- ❑ Other

Privileged and Confidential (cf. EC § 1175.6 WIC § § 4070, 4071, 5328)
A copy of this report should not be included in the client's clinical/medical record

Alleged Abuse, client was the ☐ perpetrator ☐ victim ☐ neither

- ❑ Child abuse
- ❑ Elder abuse
- ❑ Dependent abuse

- ❑ **AWOL**
- ❑ **Alleged Inappropriate Treatment, Delay in Treatment, Documentation, and/or Discharge**
- ❑ **Other Incident**

Description of incident, including all who have been called/contacted (attach if more room is needed)**:**

Program's Own Follow-Up and/or Corrective Actions:

☐ **We are requesting a CBHS Critical Incident Review (CIR) of this incident.**

Signature of staff member completing this form:_____ Phone:_____

Program Director Signature: _____ Date:_____

Please report incident by fax: 415-252-3001 (which is secured and protected), OR by mail to CBHS, Quality Management Office, 1380 Howard St. 2nd Floor, San Francisco 94103.

(To be completed ONLY by CBHS Administration) Attach CBHS Review/Action

Program Manager Signature_____Date:_____

Quality Management Review and Action_____

_____☐ Reviewed and Filed

QM signature_____Date:_____

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