QUALITY IMPROVEMENT – CBAS INCIDENT REPORT

Date of Notification:

CBAS Name:
CBAS Address:
Name of Staff Member Reporting the Incident:

Member Name:		
Member DOB (MM/DD/YYYY):		**CIN #:**
Gender (M/F)	**Health Network**	**Diagnosis**

PHYSICIAN/PROVIDER **Name:** **License #:**	**ADDRESS (where incident occurred)** **Name:** **Address:**
DOI (Date of Incident) (MM/DD YYYY)	

REASON FOR REFERRAL **(Check Appropriate Box)**	
☐ Diagnosis related issue	☐ Communication problem
☐ Treatment related issue	☐ Inappropriate behavior
☐ Unexpected death	☐ Service issue
☐ Utilization review issue	☐ System/Operations issue
☐ Fall, accident, etc.	☐ Fall, accident, etc. requiring admission to acute facility
☐ OTHER (please explain):	

CRITICAL INCIDENT ***[any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member]*** **(Check Appropriate Box)**	
☐ Mental anguish caused by willful use of offensive, abusive or demeaning language by caretaker	☐ Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations
☐ Knowing, reckless or intentional acts of failures to act which cause injury or death to an individual or which places that individual at risk of injury or death	☐ OTHER (please describe)
☐ Rape or assault ☐ Corporal punishment or striking of an individual	☐ Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual

SUMMARIZE THE INCIDENT

Attach related records and supporting documentation including reports made to other CalOptima departments

INCIDENT SUMMARY:

OTHER DEPARTMENTS CASE REFERRED TO:

PLEASE FORWARD TO:
CalOptima Quality Improvement Department
505 City Parkway West, Orange, CA 92868
Email: qualityofcare@caloptima.org / FAX: 657-900-1615