QUALITY IMPROVEMENT – CBAS INCIDENT REPORT

Date of Notification:		**CBAS Name:**	
Name of Staff Member Reporting the Incident :		**Address:**	

Member Name:					
Member DOB (MM/DD/YYYY):		**Gender:**	◉ Male ○ Female	**CIN:**	
Health Network:		**Diagnosis:**			

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

REASON FOR REFERRAL
Check Appropriate Box (Select Only 1 Option)

☐ 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 (Select Only 1 Option)**

☐ 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	☐ Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual
☐ Rape ☐ Assault	☐ OTHER (please describe)
☐ Corporal punishment or striking of an individual	

SUMMARIZE THE INCIDENT: Attach related records and supporting documentation including reports made to other CalOptima Health departments

INCIDENT SUMMARY:

OTHER DEPARTMENTS CASE REFERRED TO:

PLEASE FORWARD TO:

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