



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
Health Network:		CIN:	
		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)	
<input type="checkbox"/> Diagnosis related issue	<input type="checkbox"/> Communication problem
<input type="checkbox"/> Treatment related issue	<input type="checkbox"/> Inappropriate behavior
<input type="checkbox"/> Unexpected death	<input type="checkbox"/> Service issue
<input type="checkbox"/> Utilization review issue	<input type="checkbox"/> System/Operations issue
<input type="checkbox"/> Fall, accident, etc.	<input type="checkbox"/> Fall, accident, etc. requiring admission to acute facility
<input type="checkbox"/> 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)	
<input type="checkbox"/> Mental anguish caused by willful use of offensive, abusive or demeaning language by caretaker	<input type="checkbox"/> Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations
<input type="checkbox"/> 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	<input type="checkbox"/> Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual
<input type="checkbox"/> Rape Assault	<input type="checkbox"/> OTHER (please describe)
<input type="checkbox"/> 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