# *TENNCARE BEHAVIORAL HEALTH ADVERSE OCCURRENCE REPORT*

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| **Provider Name:** | **Consumer Name:** **(Last, First )** |
| **Name of Reporting Person:** | **Address:** |
| **Name/Title of Person Submitting Report:** | **SSN:** |
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| **Contact Number:** | **DOB:** |
| **Date Reported:** | **Date of Incident:** |
| | **MCO:** ☒ **UHCCP** ☐ **AmeriGroup** ☐ **BlueCare** ☐ **TennCare Select** |

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| **Persons Involved (Check all that apply)**<br>☐ **Clients**<br>☐ **Staff**<br>☐ **Persons Not Associated with Facility**<br>☐ **Other _____** | **Location of Incident**<br>☐ **Residential _____**<br>☐ **Inpatient _____**<br>☐ **Crisis Stabilization Unit (CSU) _____** |

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| **Type of Behavioral Health Adverse Occurrence (Check One)**<br>☐ **Suicide Death**<br>☐ **Non-Suicide Death**<br>☐ **Death-Cause Unknown**<br>☐ **Homicide**<br>☐ **Homicide Attempt w/significant medical intervention***<br>☐ **Suicide Attempt w/significant medical intervention***<br>☐ **Allegation of Abuse/Neglect-Including Peer to Peer (Physical, Sexual, Verbal)** | ☐ **Medical Emergency (i.e., heart attack, medically unstable, etc.)**<br>☐ **Accidental Injury w/significant medical intervention***<br>☐ **Use of Restraints/Seclusion (Physical, Chemical, Mechanical) requiring significant medical intervention***<br>☐ **Treatment Complications (medications errors and adverse medication reaction) requiring significant medical intervention***<br>☐ **Elopement (Specific to Inpatient and Residential services only, as related to minors or involuntary admits for adults )**<br><br>***Significant Medical Intervention: Requiring an ER visit or inpatient hospital stay** |

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| **Summary of Adverse Occurrence:** **(Be specific, precise and as detailed as possible)** |
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Revised: July, 2014

**Summary of Action Taken by Facility/Provider:**

- ☐ **Notified 911**
- ☐ **Taken to Physician**
- ☐ **Taken to Hospital**
- ☐ **Notified Fire Department**
- ☐ **Notified Police**
- ☐ **Notified Mental Health Case Manager**
- ☐ **Notified Parents or Next of Kin**
- ☐ **Staff Debriefing/Training**
- ☐ **Reported to DHS _____(Date)**
- ☐ **Reported to DCS _____(Date)**
- ☐ **Other(Specify) _____**

**MCO USE ONLY**

| **Summary of MCO follow up actions to address reported adverse occurrence: (Please be specific, precise and detailed as possible)** |
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**FAX TO: UnitedHealthcare Community Plan 1-888-785-1434 AmeriGroup 1-877-423-9976 BlueCare/TCS 1-866-259-0203**