

Serious Event Reporting (SER) Form
For CBOs and Network Providers
Mental Health Services

CONFIDENTIAL - DO NOT PLACE IN MEDICAL RECORD

<p>DO NOT EMAIL Please send completed form to: Behavioral Health Administration/Quality Assurance Unit 1340 Arnold Drive Ste. 200, Martinez, CA 94553 Fax: 925-957-5208</p>	<p><u>ADMIN USE ONLY</u> SERS # _____ Date Received: _____</p>
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Specific Event Type

<input type="checkbox"/> Assault	<input type="checkbox"/> Client Death – Homicide Victim	<input type="checkbox"/> Vehicle/Property Damage – Involving a Client	<input type="checkbox"/> Absent Without Leave/ Missing Client	<input type="checkbox"/> Theft – Involving Client
<input type="checkbox"/> Client Injury	<input type="checkbox"/> Client Death - Suicide	<input type="checkbox"/> Client Indecent Exposure	<input type="checkbox"/> Rx Error/Issue	<input type="checkbox"/> Facility Miss/ Near Fall
<input type="checkbox"/> Client Death - Accident	<input type="checkbox"/> Homicide Committed by Client	<input type="checkbox"/> Severe Agitation/ Aggression/Harassment	<input type="checkbox"/> Threat Involving a Weapon	<input type="checkbox"/> HIPAA/ IT Security
<input type="checkbox"/> Client Death - Natural	<input type="checkbox"/> Death – Unknown (Staff or Client)	<input type="checkbox"/> Medical Issues Involving a Client During a BH Service	<input type="checkbox"/> Client Suicide Attempt	<input type="checkbox"/> Other

Name of Individual: _____ Client Visitor Staff
 MRN (if applicable): _____ Date of Occurrence: _____ Time: _____

Other Parties Involved

Name: _____ Client Visitor Staff
 Name: _____ Client Visitor Staff

Name of program/organization where incident occurred: _____
 Contract Agency Network Provider Other

List any other locations/programs the client is open to (if applicable): _____

Brief Factual Description of Incident

Printed name of staff completing form Phone number Date

Follow Up Actions Taken to Resolve Incident

Program Manager/Supervisor Printed Name Program Manager/Supervisor Signature Date