TUFTS Health Plan

Adverse Incident Report Form

Note: This form applies to Tufts Health Unify and Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans.

Please type or print legibly and fax the completed form to Quality Management at 617.972.9474 **on the day of the incident**.

Today's date: ___/___/___

Notifications

☐ Department of Mental Health (DMH)

☐ Disabled Persons Protection Commission (DPPC)

☐ Department of Children and Families (DCF)

☐ Department of Developmental Services (DDS)

☐ Department of Youth Services

☐ Other:_____

Member name: _____Member ID #:_____

DOB: ___/___/____ Age: _____ ☐ Male ☐ Female

Facility: _____ Unit:_____City:_____

☐ Inpatient

☐ Community-based acute treatment center (CBAT)/intensive community-based treatment center (ICBAT)

☐ Transition care unit (TCU)

☐ Community Crisis Stabilization (CCS)

☐ Detox Level IV

☐ Detox Level III

☐ Other:_____

Date of incident: ___/___/____ Time of incident: ___:____

Date of discovery: ___/___/____ Time of discovery: ___:____

Type of incident:_____

Describe incident *(If absent without authorization (AWA), include search, notification, and commitment status)*:

_____

_____

_____

Describe immediate response to incident

_____

_____

_____

Restraints used: ☐ None ☐ Mechanical ☐ Chemical ☐ Physical Time in Restraints: ____:____

☐ **Please check if additional information is attached.**

Person Reporting:_____ Phone: ____-____-____

Title: _____

Signature:_____Date: ___/___/___

Form available at tuftshealthplan.com/provider