

Please fax completed forms to Optum at **844-814-5698**

Mass General Brigham Health Plan – Daily Adverse Incident Report

Notifications: DMH ___ DCF ___ DYS ___ DPPC ___ DDS ___ Other ___

Client: _____ **Social Security #:** _____

M ___ **F** ___ **DOB:** _____ **Age:** _____

Facility: _____ **Unit:** _____ **City:** _____

24-hour facility: ___ **Non 24-hour facility:** ___

Date and Time of Incident: _____

Date and Time of Discovery: _____

Type of Incident:

Describe Incident. If AWA, please include search, notification and commitment status:

Describe Immediate Response to the Incident*:

Restraints Used? None: ___ Mechanical: ___ Chemical: ___ Physical: ___ **Time in Restraints:** _____

Please Check if Recommended: Internal Investigation _____ Policy and Procedure Review _____

Staff training _____ Disciplinary action to staff _____

Please check if additional information is attached. _____

Person Reporting: _____ **Telephone #:** _____

Title: _____

Signature: _____ **Date:** _____

***Attach additional information if necessary**

Revised: 12/8/2022