COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
Reportable Incident Reporting Form

A reportable event is any unanticipated event resulting in death or serious physical or psychological injury to a patient or patients.

PATIENT INFORMATION			
1. Name (Last, First, and Middle):	2. Date of Birth (mm/dd/yyyy):		3. Medi-Cal or MHLA Number:
4. Address:			5. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No
6. Gender:	7. Preferred Language	8. Race/Ethnicity	
PROVIDER AGENCY WHERE INCIDENT OCCURRED			
9. Provider Agency Name:	10. Contact Person:		11. Phone Number:
12. Address:			13. Email Address:
14. Date of Incident (mm/dd/yyyy):			15. Time of Incident:

16. Reportable Incident Type:

- ☐ Death – Medical Condition
- ☐ Death – Suspected Suicide
- ☐ Death – Other
- ☐ Suicide Attempt
- ☐ Patient Injured Self (Not Suicide Attempt)
- ☐ Patient Injured another Patient, Staff, or Visitor
- ☐ Medication Error/Medication Event
- ☐ Alleged Abuse by Staff
- ☐ Other

DESCRIPTION OF THE INCIDENT

17. Please describe the nature of the incident. Include any important information about the incident, such as the date, person(s) involved, witnesses, etc. Attach any additional information, as necessary.

18. List any pre-disposing factor(s) or root cause(s) relevant to this incident:

RESPONSE AND FOLLOW UP ACTION

19. Please describe the staff response to the incident. Include a description of intervention(s) applied when dealing with the incident. Attach any additional information, as necessary.

20. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.

21. Reporting Staff Name:	22. Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to APPLICABLE Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider.*

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date: _____

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date: _____

CLINICAL INCIDENT FORM INSTRUCTIONS

PATIENT INFORMATION

1. Enter the patient name in the order of last name, first name, and middle name.
2. Enter the patient date of birth.
3. Enter the patient Medi-Cal or My Health LA (MHLA) number. If the number is not known, leave the space blank.
4. Enter the patient address.
5. Enter the patient phone number. Check box to indicate if it is okay to leave a message at this phone number.
6. Enter the patient gender.
7. Enter the patient preferred language.
8. Enter the patient race/ethnicity

PROVIDER AGENCY WHERE INCIDENT OCCURRED

9. Enter the provider agency name.
10. Enter the name of the provider agency contact person.
11. Enter the contact person phone number.
12. Enter the provider agency address.
13. Enter the provider agency or the contact person email address.
14. Enter the date of incident.
15. Enter the time of incident.
16. Please describe the incident.
17. List any pre-disposing factor(s) or root cause(s) relevant to this incident.

INCIDENT RESPONSE AND FOLLOW UP ACTION

18. Please describe the staff response to the incident. Include description of intervention(s) applied to when dealing with the incident.
19. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.
20. Enter the name of the reporting staff.
21. Enter the date

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider

INTERNAL SAPC USE ONLY

This section is reserved for internal SAPC use only.

SUBMIT THE FORM TO:

Fax: (323)-725-2045
Phone: (626)-299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE
http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm