

CONFIDENTIAL

County of San Diego Behavioral Health Services

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT OF FINDINGS-ADS

*To be completed and submitted to Quality Improvement Department
within thirty (30) days of occurrence of incident*

Provider (Program) Name:

Name of Client/Participant:

Client Case Number:

Date of Incident:

1. Summary of Findings:

(Outline any clinical case conferences, meetings or investigations you conducted. Also attach copies of related newspaper articles, coroners and toxicology reports, etc.)

2. Post Committee Recommendations/Planned Improvements:

Report Completed By:

Title:

Print Name:

Date:

Program Manager Signature:

Date:

Date Faxed to County Quality Improvement:

Phone #: ()

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County of San Diego Behavioral Health Services Administration
Quality Improvement

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