Magellan HEALTHCARE SM

Magellan of Louisiana

Louisiana CSoC Adverse Incident Reporting Form

This form **must** be faxed to Magellan of Louisiana **within 24 hours** of the discovery of the incident occurrence. **Please fax to Magellan Quality Improvement Department @ 888-656-3857** or email to **LACSoCQI@magellanhealth.com**.

Member Name:	**Provider Level of Care:**
Member Number:	**Incident Location:**
Member Date of Birth:	**Date and Time of Incident:**
Gender :	**Date of Discovery:**
Diagnosis:	**Date Form Completed:**

Check any of the following categories that were involved:

	Death		Neglect		Seclusion
	Suicide		Exploitation		
	Suicide Attempt		Extortion		
	Serious Injury or Illness		Chemical Restraint		
	Abuse		Mechanical/Physical Restraint		

Description of Event: (including specifics on incident, using as many pages as necessary, numbering, dating, & signing each)

Action taken to ensure safety of all involved: (including debriefing efforts and steps to avoid similar future events)

	Yes	Parent/Guardian notified?	Date/Person notified:
	No		
	N/A		
	Yes	Law enforcement/Protective Services notified within 24 hours of discovery / notification (if applicable)?	If yes, agency and contact information:
	No		
	N/A		
	Yes	Member seen by psychiatrist, physician or nurse after incident?	If yes, treatment:
	No		
	N/A		

Signature:	Date:
Print Name:	Email:
Provider:	Phone #:

Fax to Magellan QI Department at 888-656-3857 or email to LACSOCQI@magellanhealth.com within 24 hours of the discovery of the incident.