ANNUAL OCCURRENCE REPORT

Private Psychiatric Hospitals and Crisis Stabilization Units

This report must be submitted annually. The date of submission is based on the hospital's license expiration date, or the anniversary of that date, but the report should not be submitted with the license renewal application. Please enter the total number of each of the following events that have occurred at your facility within the full 12-month period preceding the month in which your license expires (for example, if your license expires anytime in July, 2004, the Annual Occurrence Report should cover the period of July 1, 2003 through June 30, 2004). The total number of reported occurrences must include data from all locations under this license number, including any multiple location sites or outpatient clinics. This information will be completely de-identified, and the reports will be destroyed after the information is reviewed and compiled. Reports should be placed in an envelope stamped "CONFIDENTIAL" and mailed to: Jane Guerrero, Manager, Facility Licensing Group/MC 2835, Department of State Health Services, 1100 W. 49th Street, Austin, Texas, 78756.

Occurrence Description	Total Number
A medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient	
The suicide of a patient in a setting in which the patient received care 24 hours a day	
The sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility	
A hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities	
A patient death or serious disability associated with the use or function of a device designed for a patient that is used or functions other than as intended	

Facility Name: _____
License Number: _____

Month Facility License Expires: _____

12-month reporting period covered by this report: From_____ To_____

Contact person's name: _____

Telephone Number: _____

Email mail address: _____

Refer to the Patient Safety website at http://www.dshs.state.tx.us/hfp for more information on completing this form*

**** ***Confidentiality Notification*** ****

§577.054 of the Health and Safety Code prescribes confidentiality provisions and disclosure restrictions for the information submitted on this form.