STATE OF FLORIDA
Rick Scott, Governor

PHYSICIAN OFFICE ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office

Street Address

City | Zip Code | County

Telephone

Name of Physician or Licensee Reporting

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient Name

Age | Gender | ❑ Medicaid ❑ Medicare

Patient's Address

Date of Office Visit

Patient Identification Number

Purpose of Office Visit

Diagnosis

ICD-9 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

Incident Date and Time

Location of Incident:
❑ Operating Room ❑ Recovery Room
❑ Other_____

Note: If the incident involved a death, was the medical examiner notified? ❑ Yes ❑ No
Was an autopsy performed? ❑ Yes ❑ No

A) Describe circumstances of the incident (narrative)

(use additional sheets as necessary for complete response)

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

_____

D) Outcome of Incident (Please check)

❑ Death ❑ Brain Damage ❑ Spinal Damage ❑ Surgical procedure performed on the wrong patient. ❑ A procedure to remove unplanned foreign objects remaining from surgical procedure. ❑ Any condition that required the transfer of the patient to a hospital. Outcome of transfer – e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: _____	❑ Surgical procedure performed on the wrong site ** ❑ Wrong surgical procedure performed ** ❑ Surgical repair of injuries or damage from a planned surgical procedure. ** if it resulted in: ❑ Death ❑ Brain Damage ❑ Spinal Damage ❑ Permanent disfigurement not to include the incision scar ❑ Fracture or dislocation of bones or joints ❑ Limitation of neurological, physical, or sensory function. ❑ Any condition that required the transfer of the patient to a hospital.

E) List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers.

_____

_____

_____

_____

F) List witnesses, including license numbers if licensed, and locating information if not listed above

_____

_____

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

_____

_____

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

_____

_____

V.

_____ _____
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT **LICENSE NUMBER**

_____ ____ _____
DATE REPORT COMPLETED **TIME REPORT COMPLETED**