



**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

Name of Physician

Street Address

Name of Licensee Reporting, if applicable

City, Zip Code County

Office Surgery Center License Number, if applicable

II. PATIENT INFORMATION

Patient Name

Date of Birth Gender Medicaid Medicare

Patient's Address

Date of Office Visit

Patient Identification Number

Purpose of Office Visit

Diagnosis

ICD-10 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-10 CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident. (ICD-10 Codes 01-99.9)

Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-10 E-Codes)

Resulting injury (ICD-10 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)

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