

## **Abortion Clinic Incident Report Form**

The clinic must send this report to the agency within 10 calendar days after the occurrence of the incident. All fields are required. Refer to Section 390.012(3)(h), Florida Statutes and 59A-9.029, Florida Administrative Code

First Name	1. Provider Inform	nation		4	174					
Street Address  City	License Number									
City County State Zip  Telephone Number Fax Number  2. Patient Information - Complete a separate form for each patient involved  First Name Last Name Date of Birth Age  Street Address  City County State Zip  3. Incident Information  A. DATES AND TIMES - Dates and times of the incident and discovery may differ Date and Time of the Incident Date and Time of Discovery  B. SERIOUS INJURY(S) - Select all that apply  Death (also report to the Department of Health) Perforation of the Uterus Cervical Injury Hemorrhage/Excessive Bleeding Embolism Panage to Other Organs List: Any other incident that required specialized medical attention or surgical intervention List: Any condition that required the transfer of the patient to a hospital or other health care provider	Name of Abortion Clinic			· · · · · · · · · · · · · · · · · · ·				50 300 00 00 00 00 00 00 00 00 00 00 00 0		
Telephone Number  Fax Number  Patient Information - Complete a separate form for each patient involved  First Name  Last Name  Date of Birth Age  Street Address  City  County  State  Zip  An DATES AND TIMES - Dates and times of the incident and discovery may differ Date and Time of the Incident  Date and Time of Discovery  B. SERIOUS INJURY(S) - Select all that apply Death (also report to the Department of Health) Death (also report to the Department of Health) Death (also report to the Department of Health) Any order incident that required specialized medical attention or surgical intervention List: Any condition that required the transfer of the patient to a hospital or other health care provider	Street Address				-				1 147	
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Any other incident that required specialized medical attention or surgical intervention List:  Any condition that required the transfer of the patient to a hospital or other health care provider		ns			Infec	tion				
Any condition that required the transfer of the patient to a hospital or other health care provider	Any other incident that in List:									
The same Address to which the patient was transferred.	Any condition that requi	red the transfer hich the patient	of the pation	ent to a ho ferred:	ospital	or other health	care pro	ovider		

C. Circumstand	es of the In	cident (Narrative of	Facts)					
Describe the incident in chronological order with the dates and times of the events. Include the circumstances leading up to the incident as well as action taken during and after the incident. Provide the names of all persons and providers								
involved. Attach a	idditional paç	jes, if needed.		2 10 10 10 10 10 10 10 10 10 10 10 10 10				
			in wit					
. Person Re	porting							
Title (Mr., Ms., Dr.)	First Name		Last Name	)	License Number (if applicable)			
Telephone Number		Fax Number		E-mail Address				
Signature		140		Position Title	Date			
RETURN THIS COMP								
AGENCY FOR HEAL OFFICE OF RISK MA 2727 MAHAN DR., M: TALLAHASSEE FL 3	NAGEMENT A S 16	MINISTRATION AND PATIENT SAFET	Y					
Questions?								
Review the information 412-3731	n available at h	nttp <u>://ahca.myflorida.co</u>	<u>m/</u> or contact	the Office of Risk Manage	ement and Patient Safety at (850)			