



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

1. Provider Information

License Number			
Name of Abortion Clinic			
Street Address			
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	
<input type="checkbox"/> Death (also report to the Department of Health)	<input type="checkbox"/> Perforation of the Uterus
<input type="checkbox"/> Cervical Injury	<input type="checkbox"/> Hemorrhage/Excessive Bleeding
<input type="checkbox"/> Embolism	<input type="checkbox"/> Anesthesia Complications
<input type="checkbox"/> Damage to Other Organs List:	<input type="checkbox"/> Infection
<input type="checkbox"/> Any other incident that required specialized medical attention or surgical intervention List:	
<input type="checkbox"/> Any condition that required the transfer of the patient to a hospital or other health care provider Name and Address to which the patient was transferred:	

C. Circumstances of the Incident (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 additional pages, if needed.

4. Person Reporting

Title (Mr., Ms., Dr.)	First Name	Last Name	License Number (if applicable)
Telephone Number	Fax Number	E-mail Address	

Signature

Position Title

Date

RETURN THIS COMPLETED FORM TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF RISK MANAGEMENT AND PATIENT SAFETY
2727 MAHAN DR., MS 16
TALLAHASSEE FL 32308-5407

Questions?

Review the information available at <http://ahca.myflorida.com/> or contact the Office of Risk Management and Patient Safety at (850) 412-3731