



**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 Office of Visit

Patient Identification Number

Purpose Office of 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**