



Physician Office Adverse Incident Report

1. OFFICE INFORMATION

Office Name: _____

Address: _____
 Street City State ZIP

County: _____ Office Surgery Center License #: _____
 (if applicable)

Physician Name: _____ Name of Licensee Reporting: _____
 (if applicable)

2. PATIENT INFORMATION

Patient Identification #: _____ Medicaid Medicare

Patient Name: _____ Date of Birth: _____ Gender: _____
 MM/DD/YYYY

Address: _____
 Street City State ZIP

Date of Visit: _____ Purpose of Visit: _____
 MM/DD/YYYY

Diagnosis: _____

ICD-10 Code: _____ Level of Surgery: I II III
 (description of incident)

3. INCIDENT INFORMATION

Location of Incident: Operating Room Recovery Room Other: _____

Incident Date: _____ Incident Time: _____ AM PM
 MM/DD/YYYY

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 (use additional sheets if necessary)

B.

ICD-10 CM Codes	
Surgical, diagnostic, or treatment procedure being performed at time of incident. (ICD-10 Codes 01-99.9)	
Accident, event, circumstance, or specific agent that caused the injury or event. (ICD-10 E-Codes)	
Resulting injury (ICD-10 Codes 800-999.9)	

Office Name: _____ Patient Identification #: _____

C. List any equipment used if directly involved in the incident (use additional sheets if necessary)

D. Outcome of incident

Death	Brain Damage	Spinal Damage
Surgical procedure performed on the wrong patient.		
A procedure to remove unplanned foreign objects remaining from surgical procedure.		
Surgical repair of injuries or damage from a planned surgical procedure.		
Surgical procedure performed on the wrong site **		
Wrong surgical procedure performed **		
Any condition that required the transfer of the patient to hospital. Outcome of transfer (e.g., death, brain damage, observation only _____) Name of facility to which patient was transferred: _____		

** 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 individuals, including license numbers if licensed, locating information, and the capacity in which they were involved in this incident. This includes anesthesiologist, support staff, and other healthcare providers.

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

4. ANALYSIS AND CORRECTIVE ACTION

A. Analysis of this incident and apparent cause (use additional sheets if necessary)

B. Describe corrective or proactive action(s) taken (use additional sheets if necessary)

5. SIGNATURE

Signature: _____ License #: _____
Physician /Licensee Submitting Report

Date Report Completed: _____ Time Report Completed: _____ AM PM
MM/DD/YYYY