Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, FL 32399-3275

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: ☐ 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

Office Name: _____ Patient Identification #: _____

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)**	

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