STATE OF FLORIDA
Rick Scott, Governor

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 of Office Visit
Patient Identification Number
Purpose of Office Visit
Diagnosis
ICD-9 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)

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

DH-MQA1030-12/06
Page 1 of 2
### B) ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)</th>
<th>Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)</th>
<th>Resulting injury (ICD-9 Codes 800-999.9)</th>
</tr>
</thead>
</table>

### 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)

- Death
- Brain Damage
- Spinal Damage
- Surgical procedure performed on the wrong patient.
- A procedure to remove unplanned foreign objects remaining from surgical procedure.
- Any condition that required the transfer of the patient to a hospital.

**Outcome of transfer – e.g., death, brain damage, observation only**

**Name of facility to which patient was transferred:**

- Surgical procedure performed on the wrong site **
- Wrong surgical procedure performed **
- Surgical repair of injuries or damage from a planned surgical procedure.

** 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 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

<table>
<thead>
<tr>
<th>DATE REPORT COMPLETED</th>
<th>TIME REPORT COMPLETED</th>
</tr>
</thead>
</table>

DH-MQA1030-12/06
Page 2 of 2