Hospital Initial Report of Event

Maryland
DEPARTMENT OF HEALTH

Section I: General Information

Hospital Name *

Select

Select the name of your facility from the dropdown menu.

Name of Person Completing this Report *

Enter the name of the person reporting along with the title.

Title of Person Completing this Form *

Phone Number *

+1 (___) ___-____

Enter your phone number.

Email *

*Please note that notifications will be sent to all emails provided.

Enter contact email addess. An additional address can be entered to receive communication on the event by adding a comma to separate addresses.

Event Date *

Discovery Date *

Enter the event date and the date the organization discovered the event was reportable.

Location of Event *

Enter the location of the event and the area of service.

Area or Service *

Select

Event Type *

Please review the Adverse Event Reporting Categories Sheet to identify the event type and event subtype.

Select

Select the event type based on the list of categories.

Was the Joint Commission (TJC) notified? *

Yes No

Indicate if the Joint Commission was notified.

Section II: Patient Information

How many patients were involved? *

1 2 3 4 5 or more patients

Indicate how many patients were involved in the adverse event. This will expand to enter:

- Initials
- Age
- Race, Ethnicity, Gender, Language

Section III: Intentionally Unsafe Acts

If the event was the result of an intentionally unsafe act such as abuse, please complete the following:

Was the event considered an intentionally unsafe act? *

Yes No

Indicate if the event was due to an intentionally unsafe act. Selecting yes will expand the form to enter:

- Position/Title
- License number/ Professsional board notified
- Employed through contract or agency
- Police notification

Section IV: Equipment

Was the event a result of equipment or medical device malfunction or failure please provide the following information? *

- ○ Yes
- ◉ No

Section V: Description of the Event

Briefly describe the event and include the outcome to the patient. *

☐ Send me a copy of my responses

Submit

Indicate if the event involved an equipment malfunction. Selecting yes will expand the form to enter:

- Name of equipment
- Model Number/ Nature of Malfunction
- FDA notification

Enter brief description of the event. Do not Include a timeline which should be submitted with the RCA document.