Maryland
DEPARTMENT OF HEALTH

*Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary*

Please send encrypted reports and RCAs to hospital.selfreport@maryland.gov

# INITIAL REPORT OF AN ADVERSE EVENT

## SECTION I: GENERAL INFORMATION

Hospital Name:_____

Person completing this report: _____

Title:_____Phone Number:_____Email:_____

Date of Report:_____Date of Event:_____

Location of Event:_____

Area or Service (e.g. ED, OR, Med/Surg etc.):_____

Date of Discovery:

Was TJC notified? YES ◯ NO ◯

## SECTION II: PATIENT INFORMATION

**Patient #1** initials or patient number only: _____

Date of Admission:_____Age:_____

Admitting Diagnosis: _____

Current Status:_____

Prognosis:_____

Was the patient /family informed of the adverse event? YES ◯ NO ◯

**Patient #2** initials or patient number only: _____

Date of Admission:_____Age:_____

Admitting Diagnosis: _____

Current Status:_____

Prognosis:_____

Was the patient /family informed of the adverse event? YES ◯ NO ◯

**SECTION III: INTENTIONALLY UNSAFE ACTS**

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

Position/Title:_____License #_____ If the staff person was licensed or certified, was the applicable professional board notified?

YES ◯ NO ◯

If the staff is employed through an agency or through a contract company and is not a hospital employee or member of the medical staff, please provide the employer's name.

_____

If the police were notified, please provide the jurisdiction and the report number if known:_____

**SECTION IV: EQUIPMENT**

If the event was the result of equipment or medical device malfunction or failure please provide the following information.

Equipment or Device:_____Model number:_____

Nature of Malfunction: _____

_____

Was FDA Notified? YES ◯ NO ◯

**SECTION V: DESCRIPTION OF THE EVENT:** (Briefly describe the event and include the outcome to the patient, use additional pages if necessary)