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.):______________________________
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)