

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Health Care Quality Maryland Hospital Safety Program 7120 Samuel Morse Drive Second Floor Columba MD 21046

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 r				
Title:	Phone Number:Email:		Email:	
Date of Report:			ent:	
Location of Event:				
Area or Service (e.g. ED	O, OR, Med	d/Surg etc.):		
Was TJC notified?	YES	NO		
SECTION II: PATIEN Patient #1 initials or pati				
Date of Admission:		-		
Admitting Diagnosis:				
Current Status:				
Prognosis:				
Was the patient /family	informed o	of the adverse even	at? YES NO	

Patient #2 initials or patient nu	umber only:
Date of Admission:	Age:
Admitting Diagnosis:	
Current Status:	
Prognosis:	
Was the patient /family inform	med of the adverse event? YES NO
SECTION III: INTENTIO	NALLY 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 license	ed or certified, was the applicable professional board notified?
YES	NO
If the staff is employed throu	gh an agency or through a contract company and is not a
hospital employee or membe	r of the medical staff, please provide the employer's name.
If the police were notified, pl	ease provide the jurisdiction and the report number if
known:	
SECTION IV: EOUIPMEN	<u>NT</u>
If the event was the result of	equipment or medical device malfunction or failure please
provide the following inform	ation.
Equipment or Device:	Model number:
Nature of Malfunction:	
Was FDA Notified? YES	S NO

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