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

Name of Physician

Street Address

Name of Licensee Reporting, if applicable

City, Zip Code, County

Office Surgery Center License Number, if applicable

II. PATIENT INFORMATION

Patient Name

Date of Birth Gender ❑ Medicaid ❑ Medicare

Patient's Address

Date of Office Visit

Patient Identification Number

Purpose of Office Visit

Diagnosis

ICD-10 Code for description of incident

Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

Incident Date and Time

Location of Incident:
❑ Operating Rm ❑ Recovery Rm
❑ 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, Revised 05/2019
Rule 64B15-14.0075, FAC

B) ICD-10 CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-10 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-10 E-Codes)**	Resulting injury **(ICD-10 Codes 800-999.9)**

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 outcome of the patient to a licensed 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 outcome of the patient

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

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 | LICENSE NUMBER

DATE REPORT COMPLETED | TIME REPORT COMPLETED