SUBMIT TO:
Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, FL 32399-3275

Physical Therapy Dry Needling Adverse Medical Incident Report

1. OFFICE INFORMATION

Office Name: _____

Address: _____
Street City State ZIP

County: _____ Physical Therapist Name: _____

Name of Licensee Reporting: _____
(if applicable)

2. PATIENT INFORMATION

Patient Identification #: _____

Patient Name: _____ Date of Birth: _____ Gender: _____
MM/DD/YYYY

Address: _____
Street City State ZIP

Date of Visit: _____ Purpose of Visit: _____
MM/DD/YYYY

Diagnosis: _____

3. INCIDENT INFORMATION

Location of Incident: _____

Incident Date: _____ Incident Time: _____ AM PM
MM/DD/YYYY

Office Name: _____ Patient Identification #: _____

A. Describe circumstances of the incident (use additional sheets if necessary)

_____

_____

B.

ICD-10 CM Codes	

C. List any equipment used if directly involved in the incident (use additional sheets if necessary)

_____

D. What region of the body were you treating?

_____

E. Which of the following systems were involved? Adverse Incident (Click or Check)

☐Limitation of Neurological Function (circle one) Sensory Motor Autonomic
☐Limitation of Pulmonary Function
☐Limitation of Vascular Function
☐Limitation of Musculoskeletal Function-Region (circle one): Head and Neck Thoracic region Lower back Upper Extremity: _____ Lower Extremity: _____
☐Prolonged and/or emergent condition that required transfer to hospital or physician referral for treatment of resulting condition
☐Other: _____ _____ _____ _____ _____ _____

Office Name: _____ Patient Identification #: _____

F. Describe Action Taken:

_____

_____

_____

☐Referred to Physician
☐Transported to Hospital

5. SIGNATURE

Signature:_____ License #:_____
Physical Therapist /Licensee Submitting Report

Date Report Completed: _____ Time Report Completed: _____ AM PM
MM/DD/YYYY

Office Name: _____ Patient Identification #: _____