

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH ADVERSE EVENT REPORTING FORM



DEMOGRAPHIC DATA – All Facilities

FACILITY INFORMATION:

Type of Facility: <input type="checkbox"/> Chronic Disease Hospital <input type="checkbox"/> General Hospital/Children's Hospital	<input type="checkbox"/> Hospital for Mentally Ill Persons <input type="checkbox"/> Hospital for the Care of Hospice Patients <input type="checkbox"/> Maternity Hospital <input type="checkbox"/> Outpatient Surgical Facility
Facility Name and Address:	License Number:
	Sequential Report Number:
Reporter's Name:	
Contact Person: Name:	Telephone Number:

PATIENT INFORMATION:

Medical Record Number:	Age	Date of Admission:
Patient's Billing Number:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date and Time of Event: Date: Time:
		Date and Time Event First Known: Date: Time:
Date of Patient Death (if applicable):		
Admission Diagnosis:		

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
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P.O. Box 340308 Hartford, CT 06134
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DEPARTMENT OF PUBLIC HEALTH
ADVERSE EVENT REPORTING FORM
HOSPITALS & OUTPATIENT SURGICAL FACILITIES

Sequential Report Number _____

DEMOGRAPHICS – Hospitals Only

<input type="checkbox"/> Inpatient <input type="checkbox"/> Hospital Based <input type="checkbox"/> Off Campus Satellite Site Name: _____ Address _____	<input type="checkbox"/> Outpatient <input type="checkbox"/> Hospital Based <input type="checkbox"/> Off Campus Satellite Site Name: _____ Address _____
LOCATION OF OCCURENCE: <input type="checkbox"/> Medical Intensive Care <input type="checkbox"/> Neonatal Intensive Care <input type="checkbox"/> Surgical Intensive Care Unit <input type="checkbox"/> Adult Medical <input type="checkbox"/> Adult Surgical <input type="checkbox"/> Ambulatory Surgical <input type="checkbox"/> Cardiac Cath Lab <input type="checkbox"/> Cardiac Care <input type="checkbox"/> Dialysis <input type="checkbox"/> Emergency Department	<input type="checkbox"/> Obstetrical /Gynecological <input type="checkbox"/> Operating Room <input type="checkbox"/> Outpatient Services - Specify Type _____ <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psychiatric <input type="checkbox"/> Diagnostic Services – Specify Type: _____ <input type="checkbox"/> Rehabilitative Services – Specify Type: _____ <input type="checkbox"/> Other _____

NOTIFICATIONS:

PATIENT AND/OR AUTHORIZED REPRESENTATIVE NOTIFIED OF EVENT: Y Date notified _____ N

DID THE PATIENT EXPIRE? Y N

If yes:

MEDICAL EXAMINER NOTIFIED Y <input type="checkbox"/> N <input type="checkbox"/>	AUTOPSY PERFORMED (if applicable) Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>
CASE NUMBER (if applicable) _____	LOCATION: _____

At the time of this report, were any other entities known to have been notified of this event?

Check all that apply:	
<input type="checkbox"/> Centers for Medicare/Medicaid Services <input type="checkbox"/> Department of Children and Families <input type="checkbox"/> Food and Drug Administration <input type="checkbox"/> Joint Commission on the Accreditation of Health Care Organizations	<input type="checkbox"/> Local/State Police <input type="checkbox"/> Office of Protection and Advocacy for Persons with Disabilities <input type="checkbox"/> State Fire Marshal <input type="checkbox"/> Department of Social Services, Protective Services <input type="checkbox"/> Unknown to reporter at time of report

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Sequential Report Number

"CUT & PASTE" DESCRIPTION OF EVENT HERE FROM LIST

Facts of Event and Status of Patient Condition:

Immediate Plan of Action:

FOR DPH USE ONLY

Date Report Received- Emergent	
Date Report Received	
Date Corrective Action Plan Received	

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CORRECTIVE ACTION PLAN (CAP)

Facility:	Sequential Report Number for which this plan is being submitted:
Patient Billing Number:	Date CAP Submitted:
Event being addressed:	
Findings:	
Corrective Action Plan to prevent reoccurrence:	
Does JCAHO require a root cause analysis for this event? Y <input type="checkbox"/> N <input type="checkbox"/>	
Time line for implementation:	Completion date for CAP:
Identification of staff member, by title, who has been designated the responsibility for monitoring CAP implementation:	
Submitted by:	Date:

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