EVENT REPORT FORM

DISSATISFIED PATIENT/FAMILY

Patient Safety/Risk Management Only
☐**Serious Event* (use other form)**
☐ **Incident* (use other form)**
☐ **Infrastructure Failure* (use other form)**
☐**Other**

***Confirmation date: _____/____/____**

Is the Event Related to a Specific Patient? ☐Yes ☐No

Name, MR#, Date of Birth, and Zip Code of person involved

IF EVENT IS RELATED TO SPECIFIC PERSON, PLEASE COMPLETE THIS SECTION:

Patient Classification: ☐Inpatient ☐Outpatient ☐Clinic Patient ☐ED patient ☐Home Care ☐Resident ☐Swing Bed ☐Visitor

Sex Assigned at Birth or Gender/Sex from medical record: ☐Female ☐Male

Gender Identity: ☐Female ☐Male ☐Transgender ☐Non-binary or Genderqueer ☐Something else ☐Patient declined to answer ☐Not asked

Sexual Orientation: ☐Bisexual ☐Lesbian, gay or homosexual ☐Straight or heterosexual ☐Something else ☐Patient declined to answer ☐Not asked

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Other ☐Patient declined to answer ☐Not Asked

Ethnic Group: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other ☐Patient declined to answer ☐Not Asked

Date of Admission/Ambulatory Encounter: ___/___/___ **DIAGNOSIS AND/OR PROCEDURE AT TIME OF EVENT** _________________

Patients Physician:__________________________ **Advised?** ☐Yes ☐No

TO BE COMPLETE FOR ALL EVENTS: Date of event ___/___/___ **Time (military)**________

Location of event: Care Area Name:_________________________**Care Area Type:**_________________________

How was this event discovered? (Check all that apply):

☐Assessment after event ☐Report by family or visitor ☐Report by patient ☐Report by resident, fellow, or student
☐Report by staff member ☐Review of record or chart ☐Witnessed/Involved

Individual preparing report: *(print name)*_________________________**Dept**_________________________**Date of report** ___/___/___

HARM SCORE: ☐**N/A**

Incident (No Harm): (If NOT related to a patient must be A)
☐A Circumstances that could cause adverse event
☐B-1 No harm: did not reach pt. because of chance alone
☐B-2 No harm: did not reach pt. because of active recovery
☐C No harm: reached patient
☐D No harm: Monitoring required to confirm no harm

Serious Event (Harm or Death): Event occurred that contributed to/resulted in
☐E Temporary harm and required treatment or intervention
☐F Temporary harm and required initial or prolonged hospitalization
☐G Permanent harm
☐H Near-death event (required ICU care or other life sustaining intervention)
☐I Death

Type of Outcome/Injury:____

BRIEF FACTUAL DESCRIPTION OF EVENT (*Facts, no opinions*)**:** ____

____
____
____
____
____

Did event result in new orders for treatment by physician? ☐Yes ☐No. **If yes, describe patient's treatment:** ____________________

____
____
____

Individual preparing report: *(print name)*_________________________**Dept**_________________________**Date of report** ___/___/___

Contact Information (if different from above):____

Did Health IT cause or contribute to this event? ☐Yes ☐No ☐Unknown (If yes complete Health IT/Telehealth Form)

Was this event related to a telehealth visit? ☐Yes ☐No (If yes complete Health IT/Telehealth Form)

DISSATISFIED PATIENT/FAMILY

Attitude: ☐concerned ☐inquiring ☐mild ☐very angry

Complaint:	**Physician Complaint:**	**Staff Complaint:**
◊ Accessibility/Timeliness	◊ Accessibility/Timeliness (Physician)	◊ Accessibility/Timeliness (Staff)
◊ Accommodation	◊ Accommodation (Physician)	◊ Accommodation (Staff)
◊ Attitude/Courtesy	◊ Attitude/Courtesy (Physician)	◊ Attitude/Courtesy (Staff)
◊ Billing Issue	◊ Quality of Care (Physician)	◊ Quality of Care (Staff)
◊ Dietary	◊ Other (specify)__________________	◊ Other (specify)__________________
◊ Loss	***Name of physician involved:***	***Name of staff person involved:***
◊ Quality of Care		
◊ Other (specify)__________________		

____ ____________________

Signature: Department Director/Supervisor (indicates review) ***Date***

Please forward to Risk Management or Patient Safety Officer (per Hospital Procedure) when complete.

DO NOT COPY – NOT A PART OF MEDICAL RECORD *(Confidential per Section 311 of PA Act 13 of 2002).*