



INFRASTRUCTURE FAILURE

EVENT REPORT FORM

Patient Safety/Risk Management Only
Serious Event* (use other form)
Incident (use other form)
Infrastructure Failure*
Other
PA-PSRS#
*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
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: Incident (No Harm): (If NOT related to a patient must be A) Serious Event (Harm or Death): Event occurred that contributed to/resulted in
A Circumstances that could cause adverse event E Temporary harm and required treatment or intervention
B-1 No harm: did not reach pt. because of chance alone F Temporary harm and required initial or prolonged hospitalization
B-2 No harm: did not reach pt. because of active recovery G Permanent harm
C No harm: reached patient H Near-death event (required ICU care or other life sustaining intervention)
D No harm: Monitoring required to confirm no harm 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 / /
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)

Table with 3 columns: Administration/Management, Criminal/Potentially Criminal or Illegal activity, Emergency Services/Response. Includes sub-sections like Capacity and Physical Plant/Utilities/Service Disruption.

Signature: Department Director/Supervisor (indicates review) Date
Please forward to Risk Management or Patient Safety Officer (per Hospital Procedure) when complete.