Print a copy for your records before closing. Information typed into a PDF form will not be saved.

ADVERSE EVENTS REPORT FORM

Model

*****Reporting is required only when not filing a claim*****

Recipient Last Name: _____

Recipient First Name: _____

Recipient Date of Birth: _____ mm/dd/yyyy

Recipient Medicaid ID#: _____

Event Occurrence Date: _____ mm/dd/yyyy

Event Type: Choose an item.

- ☐ Foreign Object Retained After Surgery
- ☐ Surgery on wrong patient
- ☐ Wrong surgery on patient
- ☐ Surgery performed on wrong body part
- ☐ Air Embolism
- ☐ Death/disability associated with incompatible blood
- ☐ Stage 3 or 4 pressure ulcers after admission
- ☐ Death/disability associated with a fall, burn, or electric shock within facility
- ☐ Post –operative death in normal healthy patient