

# Office-Based Surgery - Adverse Event Report

## 1. Name of Person Completing Report

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

Title  MD/DO  PA  SA  Other, specify: \_\_\_\_\_

## 2. License Number

## 3. Legal Name of Practice

## 4. Phone #

( ) \_\_\_\_\_

## 5. Address Where Procedure Performed

ADDRESS 1 \_\_\_\_\_

ADDRESS 2 \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## 6. Name/ License #(s) of Person(s) who Administered Anesthesia

### a. Individual who determined drug and dosage

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

LICENSE # \_\_\_\_\_

### b. Individual who administered medication

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

LICENSE # \_\_\_\_\_

## 7. Name/License #(s) of Other Person(s) Participating in Procedure

a. LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

LICENSE # \_\_\_\_\_

b. LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

LICENSE # \_\_\_\_\_

c. LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

LICENSE # \_\_\_\_\_

## 8. Patient Name

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

## 9. Patient DOB

MM \_\_\_\_ DD \_\_\_\_ YY \_\_\_\_

## 10. Patient Gender

M  F

## 11. Patient Address

ADDRESS 1 \_\_\_\_\_

ADDRESS 2 \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## 12. Procedure Date

MM \_\_\_\_ DD \_\_\_\_ YY \_\_\_\_

**13. Procedure Code(s)  
and Name(s)**

Procedure HCPCS/CPT Code \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Procedure Name \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**14. Adverse Event Date**

MM DD YY

**15. Reportable  
Adverse Event**

- a.  Patient Death within 30 Days
- b.  Unplanned Transfer to a Hospital
- c.  Unscheduled Hospital Admission for longer than 24 hours within 72 hours of undergoing OBS
- d.  Any Serious or Life-Threatening Event

**Hospital Name and Address**

NAME \_\_\_\_\_  
ADDRESS 1 \_\_\_\_\_  
ADDRESS 2 \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**16. Description of Actions  
Leading to and  
Including the  
Reportable Event**

Please attach  
additional pages  
if needed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**17. Date of Report**

MM DD YY

**18. Signature of Reporter**

SIGNATURE \_\_\_\_\_  
TITLE \_\_\_\_\_

**Print Name**

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

**\*Such adverse events shall be reported to the PSC within one business day of the occurrence of such adverse event.** It is expected that in most cases the physician, PA or SA will become aware of the reportable adverse event within one business day of its occurrence through the patient, a subsequently treating physician and/or hospital, an insurer and/or family member. If you learned of this adverse event later than within one business day of its occurrence please provide a description of the factors that prevented you from learning of such event within this time frame (please attach additional pages if needed).

Please submit Adverse Event Form via certified mail to: **New York State Department of Health  
Patient Safety Center  
161 Delaware Avenue  
Delmar, New York 12054**