NEW YORK STATE DEPARTMENT OF HEALTH
Patient Safety Center

Office-Based Surgery - Adverse Event Report

1. Type of Reportable Adverse Event being reported (please check all that apply):

☐ Patient death within 30 days

☐ Unplanned transfer to a hospital (Please note hospital information below) Transferring EMS Service: _____

☐ Unscheduled hospital admission for longer than 24 hours within 72 hours of undergoing OBS Procedure (Please note hospital information below)

☐ Any serious or life-threatening event (See Provider FAQ's on DOH OBS website for definitions; http://www.health.ny.gov/professionals/office-based_surgery/obs_faq.htm)

☐ Any suspected transmission of a bloodborne pathogen (BBP) from a health care professional to a patient or between patients. See BBP addendum at the end of this form.

HOSPITAL NAME _____

ADDRESS 1 _____

ADDRESS 2 _____

CITY _____ STATE _____ ZIP _____

2. Procedure Name(s) and Code(s) Performed on involved patient:

Procedure Name: _____ CPT/HCPCS Code: _____

3. Approximately how many of the type of procedure(s) involved in this report does the primary proceduralist associated with this report perform per month: _____

4. Date OBS Procedure(s) performed: _____ MM/DD/YY

5. Indication for the procedure: ☐ Screening ☐ Diagnostic ☐ Therapeutic ☐ Elective

6. Date of Adverse Event:

Transfer _____ MM/DD/YY Admission _____ MM/DD/YY

Serious or life threatening event _____ MM/DD/YY Death _____ MM/DD/YY

7. Describe events and suspected complication(s) leading up to the unplanned transfer, unscheduled admission, death or serious or life-threatening event reported above. If pregnancy-related procedure, include gestational age of fetus. Use page 5 for additional space if needed.

8. Was the (suspected) complication or reason for the adverse event reported (e.g. transfer, admission) identified to the patient as part of the pre-procedure informed consent process? Yes No

9. Sedation/Anesthesia Related Care

a. Significant Past Medical History/Co-morbidity(s):

☐ None	☐ HTN	☐ DM	☐ CAD	☐ ESRD	☐ PAD
☐ Arrhythmias	☐ CHF	☐ TIA/CVA	☐ Asthma/COPD	☐ Anemia	☐ Pain
☐ GERD	☐ Ulcer(s)	☐ IBS/Colitis	☐ Diverticulosis	☐ Bleeding	☐ Psychiatric
☐ Seizures	☐ Obesity	☐ Advanced Stage Cancer	☐ Kidney Stones	☐ Other: _____	
☐ Pregnancy History: G: _____		P: _____	☐ Date of last adequate dialysis: _____ MM/DD/YY		

b. Patient's Current Home Medications:

☐ None	☐ Calcium Channel Blocker	☐ NSAID/ASA	☐ Steroids	☐ PPI
☐ ACE/ARB	☐ Diuretic	☐ Opiate	☐ Bronchodilators	☐ H2 Inhibitor/Antagonist
☐ Beta Blocker	☐ Insulin/Oral Hypoglycemic	☐ Anticoagulant	☐ Other: _____	

c. Number of hours since last pre-procedure PO intake: ☐ Less than 6 h ☐ 6-12 h ☐ Greater than 12 h

d. ASA Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Emergency

e. Pre-procedure Medication(s) Prescribed +/or Administered: ☐ None ☐ Anxiolytic ☐ Antibiotic ☐ Steroids ☐ Antihistamine ☐ Anticoagulant ☐ Other: _____

f. Intra and Post Procedural Medications Administered:

1. Procedural sedation/anesthesia medications ☐ None

DOSE		DOSE		DOSE	
_____	Diazepam	_____	Lorazepam	_____	Succinylcholine
_____	Fentanyl	_____	Ketamine	_____	Nitrous Oxide
_____	Morphine	_____	Propofol	_____	Local infiltration w/a "Caine"
_____	Non-depolarizing muscle relaxant	_____	Midazolam	_____	Other _____
_____	Volatile anesthetic agent	_____	Meperidine		

2. Other Procedural and Post-procedure Medications ☐ None

DOSE		DOSE		GIVEN	
_____	Contrast	_____	Nitroglycerin	☐	ACLS/Rescue medication: _____
_____	Flumazinil	_____	Ondansetron/Zofran	☐	Antibiotic(s): _____
_____	Glycopyrrolate/Rubinol	_____	Pitocin/Oxytocin	☐	Antihistamine(s): _____
_____	Heparin	_____	Protamine	☐	Bronchodilator(s): _____
_____	Methergine	_____	tPA	☐	Diuretics(s): _____
_____	Metoclopramide/Reglan	_____	Other _____	☐	Steroid(s): _____
_____	Naloxone/Narcan	_____	Other _____	☐	NSAID(s): _____

g. Level of Sedation/Anesthesia Achieved: ☐ Local/Topical ☐ Regional ☐ Neuroaxial (spinal, epidural) ☐ General Anesthesia ☐ Minimal Sedation ☐ Moderate Sedation ☐ Deep Sedation

10. Length of Procedure: ☐ < 1 hour ☐ 1 - 3 hours ☐ 3 - 6 hours ☐ > 6 hours

11. Liposuction Volume Removed: ☐ None ☐ <500 ml ☐ 501 - 1000 ml ☐ >1000 ml

12. Length of recovery time in office: ☐ < 1 hour ☐ 1 - 3 hours ☐ 3 - 6 hours ☐ > 6 hours

13. Patient Information:

LAST, FIRST, MI | GENDER | AGE | DOB (MM/DD/YY) | LAST 4 SSN DIGITS

ADDRESS 1

ADDRESS 2

CITY | STATE | ZIP

14. Name of Accredited OBS Practice and Location where procedure performed:

LEGAL NAME | Accreditation Number

ADDRESS 1

ADDRESS 2

CITY | STATE | ZIP

Name of Contact Person:

LAST, FIRST, MI | PHONE WITH AREA CODE | EMAIL

15. Quality Improvement:

a. In the opinion of the proceduralist/surgeon, *or reporter if this report is being filed by a practitioner or facility not affiliated with the practice where the OBS occurred,* the adverse event being reported is related to the:

☐ Procedure ☐ Anesthesia/Sedation ☐ Equipment Factors ☐ Patient Factors ☐ Practitioner Factors ☐ System/Practice Factors

☐ Other, please identify:

b. Please identify actions the Practice/Practitioner has taken/plans to take to prevent similar adverse events from happening in the future:

16. Accreditation: ***Effective July 14, 2009 all practices in which office-based surgery is performed must be accredited by an agency designated by the Commissioner of Health.***

a. Is your practice accredited? ☐ No ☐ Yes, with: ☐ AAAASF ☐ AAAHC ☐ TJC

b. If not yet accredited, has your practice applied for accreditation? ☐ No ☐ Yes, with: ☐ AAAASF ☐ AAAHC ☐ TJC

When do you expect to receive your OBS accreditation? _____ DATE

American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF); Accreditation Association for Ambulatory Health Care (AAAHC); The Joint Commission (TJC)

17. Reporter(s): Name(s) and Signature(s) of Reporters Attesting to the Accuracy of this Report:

(All MD, PA, SA that participated in the procedure must report; each practitioner can submit a report or multiple practitioners can sign the same report.)

Proceduralist:

PRINTED NAME | SIGNATURE | LICENSE TYPE | LICENSE NUMBER

Practice/Facility Affiliation:

☐ A member of a practice where OBS procedure occurred

☐ A member of another practice

PRACTICE NAME

STREET

CITY, STATE, ZIP | PHONE

Sedation/Anesthesia Prescriber:

PRINTED NAME | SIGNATURE | LICENSE TYPE | LICENSE NUMBER

Practice/Facility Affiliation:

☐ A member of a practice where OBS procedure occurred

☐ A member of another practice

PRACTICE NAME

STREET

CITY, STATE, ZIP | PHONE

Sedation/Anesthesia Administerer:

PRINTED NAME | SIGNATURE | LICENSE TYPE | LICENSE NUMBER

Practice/Facility Affiliation:

☐ A member of a practice where OBS procedure occurred

☐ A member of another practice

PRACTICE NAME

STREET

CITY, STATE, ZIP | PHONE

Item 17 continued on next page.

Other Practitioners Participating in the Procedure:

PRINTED NAME | SIGNATURE | LICENSE TYPE | LICENSE NUMBER

Practice/Facility Affiliation:

☐ A member of a practice where OBS procedure occurred

☐ A member of another practice

PRACTICE NAME

STREET

CITY, STATE, ZIP | PHONE

Other Practitioners Participating in the Procedure:

PRINTED NAME | SIGNATURE | LICENSE TYPE | LICENSE NUMBER

Practice/Facility Affiliation:

☐ A member of a practice where OBS procedure occurred

☐ A member of another practice

PRACTICE NAME

STREET

CITY, STATE, ZIP | PHONE

18. Date of Report: _____
MM/DD/YY

Adverse event reports must be reported within 24 hours of the event. If this report is filed more than one business day after the event, provide a description of the factors that prevented you from filing the report within the required timeframe.

Reason for delay in reporting, if applicable:

Please submit Adverse Event Form via Secure File Transfer via the DOH Health Commerce System at https://commerce.health.state.ny.us **or** via certified mail to:

Patient Safety Center
Office of Quality and Patient Safety
New York State Department of Health
Corning Tower, Room 1938
Albany, NY, 12237

ADDENDUM: Bloodborne Pathogen Transmission

Date of Suspected Transmission of Bloodborne Pathogen: _____
MM/DD/YY

Full Description of Events related to Suspected Transmission of BBP (attach additional pages if needed):

Bloodborne pathogen involved in (suspected) transmission:

Type of Transmission: ☐ Health care professional to patient ☐ Between or among patients

Number of Patients Affected:

Additional Information: