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 Date of Death Relative to OBS Procedure within: ☐ 24hrs ☐ 72 hrs ☐ 4-7days ☐ 8-30days

☐ Unplanned transfer to a hospital Transferring EMS Service: _____

☐ Unscheduled hospital admission for longer than 24 hours w/in 72 hours of undergoing OBS Procedure

☐ Any serious or life-threatening event (Examples include: permanent or temporary loss of organ or limb function or mental impairment, wrong site surgery and retained foreign body.)

☐ 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 ☐ Optional

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. Attach additional pages 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):

MEDICAL
☐ None ☐ HTN ☐ DM ☐ DVT ☐ Pain ☐ Seizures ☐ Other:
☐ ESRD ☐ CHF ☐ Asthma/COPD ☐ Stroke ☐ Bleeding ☐ Psychiatric _____
☐ CAD ☐ Arrhythmias ☐ Anemia ☐ Advanced Stage Cancer ☐ Diverticulitis ☐ Obesity _____
☐ PAD ☐ Pregnancy History: G: _____ P: _____

b. Patient's Current Home Medications:

☐ None ☐ Calcium Channel Blocker ☐ NSAID/ASA ☐ Steroids
☐ ACE/ARB ☐ Diuretic ☐ Opiate ☐ Bronchodilators
☐ 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: ☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ P5 ☐ P6 ☐ Emergency

e. Pre-procedure Medication(s) Prescribed +/or Administered: ☐ Anxiolytic ☐ Antibiotic ☐ Steroids ☐ Antihistamine ☐ Anticoagulant ☐ Other: _____

f. Intra and Post Procedural Medications Administered:

1. Procedural sedation/anesthesia medications

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

2. Other Medications

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 _____	☐	Steriod(s)
_____	Naloxone/Narcan	_____	Other _____	☐	NSAID(s)

g. Level of Anesthesia Achieved: ☐ Local/Regional ☐ Minor ☐ Moderate ☐ Deep ☐ General

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. Practitioners participating in reported OBS procedure:

a. Name of Primary proceduralist/surgeon:

LAST, FIRST, MI _____ LICENSE/CERT. TYPE _____ LICENSE # _____

b. Practitioner who determined anesthetic/sedative drug(s) and dosages:

LAST, FIRST, MI _____ LICENSE/CERT. TYPE _____ LICENSE # _____

Credential/Role: ☐ BC/BE/Anesthesiologist ☐ Proceduralist ☐ CRNA ☐ Other: _____

c. Practitioner who administered anesthesia/sedation:

LAST, FIRST, MI _____ LICENSE/CERT. TYPE _____ LICENSE # _____

d. Others participating in procedure:

LAST, FIRST, MI _____ CERT/TITLE _____ LICENSE # _____

LAST, FIRST, MI _____ CERT/TITLE _____ LICENSE # _____

LAST, FIRST, MI _____ CERT/TITLE _____ LICENSE # _____

13. Patient Information:

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

ADDRESS _____

CITY _____ STATE _____ ZIP _____

14. Location where OBS was performed:

LEGAL NAME _____ PRACTICE NPI # _____

ADDRESS 1 _____

ADDRESS 2 _____

CITY _____ STATE _____ ZIP _____

Name of Contact Person:

LAST, FIRST, MI _____ PHONE W/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.)

PRINTED NAME _____ SIGNATURE _____

Practice/Facility Affiliation:

☐ Practice where OBS occurred ☐ Other _____ PRACTICE NAME

_____ STREET

_____ CITY, STATE, ZIP _____ PHONE

PRINTED NAME _____ SIGNATURE _____

Practice/Facility Affiliation:

☐ Practice where OBS occurred ☐ Other _____ PRACTICE NAME

_____ STREET

_____ CITY, STATE, ZIP _____ PHONE

Item 17 continued on next page.

PRINTED NAME _____ SIGNATURE _____

Practice/Facility Affiliation:

☐ Practice where OBS occurred ☐ Other _____
PRACTICE NAME

_____
STREET

_____ _____
CITY, STATE, ZIP PHONE

PRINTED NAME _____ SIGNATURE _____

Practice/Facility Affiliation:

☐ Practice where OBS occurred ☐ Other _____
PRACTICE NAME

_____
STREET

_____ _____
CITY, STATE, ZIP PHONE

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

Adverse event reports must be reported w/in 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 signed Adverse Event form, via certified mail, to:

New York State Department of Health
Patient Safety Center
Hedley Park Place
433 River St
Troy, NY, 12180

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: ☐ Healthcare professional to patient ☐ Between or among patients

Number of Patients Affected: