

**Adverse Incident Report
for Planned Out-of-Hospital Births
Florida Department of Health**

Submit form to:
Department of Health, Consumer Services Unit
8052 Bald Cypress Way, Ste C-75
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Part I: Practitioner Information

Section 456.0405, Florida Statutes, requires an adverse incident, defined as an event associated with a planned out-of-hospital birth over which a physician licensed under Chapter 458 or Chapter 459, a nurse midwife certified under part 1 of Chapter 464, or a midwife licensed under chapter 467 could exercise control, to be reported to the Department of Health within 15 days of the incident. Adverse incidents include maternal death; maternal hemorrhagic shock or transfusion; fetal or newborn death including a stillbirth; certain traumatic physical or neurological birth injuries; or a transfer of a newborn to a neonatal intensive care unit under specific circumstances. This form does not replace any other adverse incident report required by the statutes and rules governing your specific profession.

Practitioner Name: _____

License Number: _____

Part II: Adverse Incident General Information

Incident Date: _____ Incident Time: _____

Address where incident occurred: _____

City: _____ State: _____ ZIP: _____

This address is at:

- ☐ Home/Private Residence
☐ Physician's Office
☐ Birthing Center (specify name): _____
☐ Other (please specify): _____

Please check all that apply:

- ☐ A maternal death occurred during delivery.
☐ A maternal death occurred within 42 days after delivery.
☐ The maternal patient was transferred to a hospital intensive care unit.
☐ The maternal patient experienced hemorrhagic shock.
☐ The maternal patient required a transfusion of more than 4 units of blood or blood products.
☐ A fetal or newborn death occurred.
☐ Y ☐ N The fetal or newborn death was a stillbirth.
☐ The newborn was transferred to neonatal intensive care due to a traumatic physical or neurological birth injury.
☐ Y ☐ N This transfer occurred due to a brachial plexus injury.

Pennsylvania Incident Report In For Hospitals

George Pozgar, Nina M. Santucci



Pennsylvania Incident Report In For Hospitals:

Pennsylvania Hospital Reports. V. 1-2, 1868-1869 Pennsylvania Hospital (Philadelphia, Pa.), 1868 *Medical Records for Attorneys* Laurence M. Deutsch, 2001 **Medical Malpractice; Report: Appendix** United States. Department of Health, Education, and Welfare. Secretary's Commission on Medical Malpractice, 1973 Report of Secretary's Commission on Medical Malpractice United States. Health, Education and Welfare Department, 1973 **Appendix: Report of the Secretary's Commission on Medical Malpractice** United States. Department of Health, Education, and Welfare. Secretary's Commission on Medical Malpractice, 1973 *Legal Essentials of Health Care Administration* George Pozgar, Nina M. Santucci, 2009-10-06 *Legal Essentials in Health Care Administration* is a distillation of the most important topics from the widely popular *Legal Aspects of Health Care Administration* by the same author Using reader friendly jargon free language this text unravels the complexities of the legal system in health care and provides the reader with a strong foundation in health law Readers will gain a solid understanding of what steps providers of care legislative bodies patients patients families and patient advocates can take to help prevent the wide variety of harmful events that are involved in health care *Department Reports of Pennsylvania*, 1916 Killer Care James B. Lieber, 2015-12-10 A succinct disturbing report on the prevalence of malpractice in modern medicine An imperative analysis that begs for discussion by industry watchdogs and consumers alike Kirkus Reviews Brilliant scholarly A reading of *Killer Care* makes an immediate personal investment in our own safer patient centered care logical and worthwhile *Killer Care* is strongly advised T Michael White M D former VP and clinical professor of medicine University of Pittsburgh Medical Center author *Unsafe to Safe In Killer Care* James Lieber uncovers systemic failures and lack of safeguards in patient safety His wake up call not only informs but provides specific and actionable recommendations for patients and their families His analysis also points to system fixes that will make being a patient safer for all of us Barbara Mittleman M D former director Program on Private Public Partnerships Office of Science Policy National Institutes of Health 2006 2012 Each year in the U S a quarter of a million deaths are attributable to medical error If the number shocks on some level you already knew it was so Everyone knows someone perhaps it was yourself who has suffered miserable treatment in American hospitals part of the most elaborate most extensive and expensive health care system in the world But it is perhaps the most inefficient Misdiagnoses wrong prescriptions operating on the wrong patient even operating on the wrong limb and amputating it these are the consequences of rampant carelessness overwork ignorance and hospitals trying to get the most out of their caregivers and the most money out of their patients What are we to do *Killer Care* lays out the very real danger each of us faces whenever we enter a hospital But more than that it spells out what we can do to mitigate that risk The book is also the story of the remarkable heroes fighting this plague of medical errors patients and their families but also doctors and nurses Starting about twenty years ago a number of victims and even some perpetrators of these errors began a social movement that offers us vital protections when we are most vulnerable they have

begun a cultural shift that is transforming every facet of health care **Pennsylvania County Court Reports** ,1918

Hospital Liability James Walker Smith,2024-10-28 Whether you represent hospitals physicians or their patients this acclaimed publication analyzes the impact of the latest statutes regulations cases and trends **Annual Report of the**

Superintendent of Soldiers' Orphans of Pennsylvania for the Year Pennsylvania. Superintendent of Soldiers'

Orphans,1914 Contains information on various Pennsylvania military orphan schools including description activities and finances with some registers of students **The Handbook of Patient Safety Compliance** Fay A. Rozovsky,James R.

Woods, Jr.,2016-12-05 Written for virtually every professional and leader in the health care field as well as students who are preparing for careers in health services delivery this book presents a framework for developing a patient safety program shows how best to examine events that do occur and reveals how to ensure that appropriate corrective and preventative actions are reviewed for effectiveness The book covers a comprehensive selection of topics including The link between

patient safety and legal and regulatory compliance The role of accreditation and standard setting organizations in patient safety Failure modes and effect analysis Voluntary and regulatory oversight of medical error Evidence based outcomes and standards of care Creation and preservation of reports data and device evidence in medical error situations Claims

management when dealing with patient safety events Full disclosure Patient safety in human research Managing confidentiality in the face of litigation Managing patient safety compliance through accountability based credentialing for health care professionals Planning for the future **Pennsylvania State Reports** Pennsylvania. Supreme Court,1894

Containing cases decided by the Supreme Court of Pennsylvania varies **Pennsylvania Superior Court Reports**

Pennsylvania. Superior Court,1912 Containing cases adjudged in the Superior Court of Pennsylvania **State Codes on**

Domestic Violence Barbara J. Hart,1994-07 A report and analysis of the achievements of legal reform efforts over the last 2 decades directed at ending domestic violence protecting its victims and both constraining and transforming its perpetrators

Identifies the array of state codes on civil protection orders child custody civil damages social and health services arrest and law enforcement responsibilities and rules of evidence for battered women defendants Offers commentary on the law and the social context in which it operates Articulates recommendations for further law reform efforts Decisions of the

Pennsylvania Workmen's Compensation Board Pennsylvania Workmen's Compensation Board,1925 Hearings, Reports

and Prints of the House Committee on Veterans' Affairs United States. Congress. House. Committee on Veterans'

Affairs,1966 *Pennsylvania State Reports Containing Cases Decided by the Supreme Court of Pennsylvania* Pennsylvania.

Supreme Court,1894 Taser Electronic Control Devices and Sudden In-custody Death Howard E. Williams,2008 After

reviewing the available evidence from this extensive case study the author concludes that these conducted energy weapons are excluded as the cause of death in 182 of the 212 cases In only two cases did the evidence tend to confirm the weapon was either a cause of death or a significant contributing factor While arguing that the TASER electronic control devices are safe

less lethal weapons the author also cautions that they are not completely effective

LEGAL ASPECTS OF HEALTH

CARE ADMIN 10E George D. Pozgar, 2007 With over 100 000 copies sold it is clear that instructors turn to George Pozgar time and again to make the legal aspects of health care administration meaningful and memorable to students the forthcoming 10th edition of this classic text has been further revised and updated with the most current information on law and the health care industry the 10th edition continues to lay a strong foundation for the reader in both ethical and legal issues critical to improving the quality and safe delivery of health care

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