



Sentinel Event Report

Facility Information

Name of Facility: _____

Person Reporting: _____ Job Title: _____

Patient/Victim Information

DoB: _____ Age: _____ Gender: M F Date of Admission: _____

Principal Admitting Diagnoses: _____

Event Information

Date of Event: _____ Time: _____ am pm Date of this report: _____

Patient's Cognitive Status Prior to Event:	<input type="checkbox"/>	Alert/Oriented	<input type="checkbox"/>	Dementia
	<input type="checkbox"/>	Mentally Retarded	<input type="checkbox"/>	Comatose
<input type="checkbox"/> Other _____	<input type="checkbox"/>	Confused	<input type="checkbox"/>	Psychotic
_____	<input type="checkbox"/>	Combative	<input type="checkbox"/>	Unknown

Location of Patient when event occurred:	<input type="checkbox"/>	Patient room	<input type="checkbox"/>	Recovery room
	<input type="checkbox"/>	Emergency room	<input type="checkbox"/>	Operating room
<input type="checkbox"/> Other _____	<input type="checkbox"/>	ICU/CCU	<input type="checkbox"/>	Radiology
_____	<input type="checkbox"/>	Procedure room	<input type="checkbox"/>	Labor/Delivery
	<input type="checkbox"/>	Laboratory	<input type="checkbox"/>	Lobby/Waiting
	<input type="checkbox"/>	Hallway/Public Area	<input type="checkbox"/>	Facility Campus

Type of Event:	<input type="checkbox"/>	Abduction	<input type="checkbox"/>	Assault	<input type="checkbox"/>	Battery
	<input type="checkbox"/>	Burn	<input type="checkbox"/>	Fall	<input type="checkbox"/>	Medication error
	<input type="checkbox"/>	Restraint	<input type="checkbox"/>	Transfusion	<input type="checkbox"/>	Suicide or attempt
	<input type="checkbox"/>	Tx delay	<input type="checkbox"/>	Tx error	<input type="checkbox"/>	Elopement or escape
	<input type="checkbox"/>	Release of secured medical information	<input type="checkbox"/>		<input type="checkbox"/>	Homicide or attempt
	<input type="checkbox"/>	Discharge to wrong family/wrong facility	<input type="checkbox"/>		<input type="checkbox"/>	Procedure complication
	<input type="checkbox"/>	Impersonation of a health professional	<input type="checkbox"/>		<input type="checkbox"/>	Contaminated/defective product or device
	<input type="checkbox"/>	Rape or attempt	<input type="checkbox"/>		<input type="checkbox"/>	Wrong patient/wrong procedure
	<input type="checkbox"/>	Wrong site/wrong procedure	<input type="checkbox"/>		<input type="checkbox"/>	Hostage
	<input type="checkbox"/>	Death as a result of this event	<input type="checkbox"/>		<input type="checkbox"/>	Other _____

How were you involved in this event? Directly Indirectly Assisted following event
Were you at fault in any way? Yes No Maybe

Narrative Description: (What led up to the event, the event, what was done, and the immediately known outcome. Be specific as to times, places, actions and people names. Give only facts. Omit emotion, blame and hear say. Use additional pages if necessary to fully describe and explain situation.)

Signature: _____