



STATE OF FLORIDA
Jeb Bush, Governor

03 MAR 12 PM 7:00

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14000,
Tallahassee, Florida 32317-4000

I. OFFICE INFORMATION

Name of office: Southeastern Urological Center, PA Street Address: 2000 Centre Pointe Blvd
City: Tallahassee Zip Code: 32308 Leon County Telephone: 850-309-0400
Name of Physician or Licensee Reporting: Raleigh W Rollins License Number & office registration number, if applicable: ME 0020010
Patient's address for Physician or Licensee Reporting: 25 2nd St

NO procedure

II. PATIENT INFORMATION

Patient Identification Number: [Redacted] Age: 3-4-03 Gender: [Redacted] Medicaid/Medicare: [Redacted]
Date of Office Visit: routine follow up
Purpose of Office Visit: NA
ICD-9 Code for description of incident: NA
Level of Surgery (II) or (III): [Redacted]

III. INCIDENT INFORMATION

Incident Date and Time: 3-4-03 @ 1530

Location of Incident:
 Operating Rm Recovery Rm
 Other Clinic Exam Room

Note: If the incident involved a death, was the medical examiner notified? Yes No
Was an autopsy performed? Yes No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Patient here for routine office visit. States [Redacted] feels funny like [Redacted] heart was racing. Called Dr. Rollins to listen to [Redacted] heart which Dr. Rollins described as rapid and regular, possible ventricular tachycardia which within minutes converted to normal sinus rhythm. Ambulance called and patient transported to TMR for further evaluation of [Redacted] cardiac status.

B) ICD-9-CM Codes

NA
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

NA
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

NA
Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete responses)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred: <u>Palmetto Memorial</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** If it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
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E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Raleigh W. Redliss MD - MD caring for patient ordering
Kathy Proven PA - PN 203951 - assisting Dr. Redliss in caring for patient
Jerry Spear RN - RN 915912 - covered transfer + stayed with patient till ambulance arrived

F) List witnesses, including license numbers if licensed, and locating information if not listed above

NA

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Patient transferred appropriately and safely for cardiac assessment. Condition unrelated to neurological diagnosis.

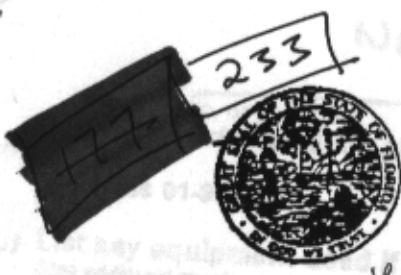
B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Patient appropriately transferred to hospital for further evaluation.

Jerry Spear for Raleigh W. Redliss MD RN 915912 / 4E0020010
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

3-3-05
DATE REPORT COMPLETED

1800 hours
TIME REPORT COMPLETED



STATE OF FLORIDA
Jeb Bush, Governor



**PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT**

SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14000,
Tallahassee, Florida 32317-4000

duplicate

I. OFFICE INFORMATION
Cancer Centers of Florida
Name of office
Orlando 32806 Orange
City Zip Code County
Dr. Vicio Hernandez
Name of Physician or Licensee Reporting
Same
Locating information for Physician or Licensee Reporting

52 West Gore Street
Street Address
407-426-8484
Telephone
ME 0073340
License Number

no procedure

II. PATIENT INFORMATION
[Redacted]
Patient Identification Number
174.4 Breast Cancer
Diagnosis

[Redacted]
3-3-2003
Date of Office Visit
Treatment / Follow-up Appt - MD
Purpose of Office Visit
174.4
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION
3-3-2003 2:00pm
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other

Note: If the incident involved a death, was the medical examiner notified? Yes No
Was an autopsy performed? Yes No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)
pt presented w/ chest pressure and shortness of breath; asked to go to the ER but stated could not drive - 911 called for transportation to ER @ ORMC

11 7:29
11 7:29
11 7:29

NIA

Diagnostic, or treatment
being performed at time of

Codes 01-99.9)

Accident, event, circumstances, or
specific agent that caused the injury
or event.

(ICD-9 E-Codes)

Resulting injury
(ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

NIA

D) Outcome of incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer of the patient to a licensed hospital	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensor function; <input type="checkbox"/> Any condition that required the transfer of the patient
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E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

Vinicio Hernandez, MD, Nicole Fernandez, CMA, Martha Cepero, CMA

F) List witnesses, including license numbers if licensed, and locating information if not listed above

same as above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

[Handwritten signature]

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT

ME 73340
LICENSE NUMBER

DATE REPORT COMPLETED
3/3/03

TIME REPORT COMPLETED
2:30 pm

①

American Board of Plastic Surgery



①

AMMMSF certified

Hospital privileges

MRMC

Vocal Regional Hospital

352 401 7000

STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

RECEIVED
CONSUMER SERVICES UNIT

03 MAR 25 AM 7:01

SUBMIT FORM TO:

Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14000,
Tallahassee, Florida 32317-4000

MRMC
351-7200

I. OFFICE INFORMATION

Cosmetic Plastic Surgery Center of Ocala
Name of office

1800 SW 17th St #700
Street Address

Ocala 34471 Marion
City Zip Code County

(352) 351-4440
Telephone

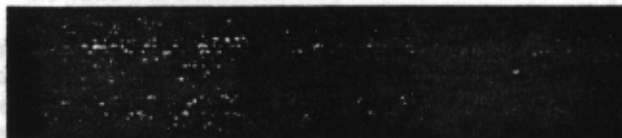
Dr John D. Cohen-Shahet
Name of Physician or Licensee Reporting

Registration # 346
License Number & office registration number, if applicable

Same as above
Patient's address for Physician or Licensee Reporting

pneumothorax - breast AUG

II. PATIENT INFORMATION



Age 31/03 Gender Medicaid Medicare

Bilateral Hypotrophic Breasts
Diagnosis

Date of Office Visit
Breast Augmentation
Purpose of Office Visit
51.21
ICD-9 Code for description of incident
Level I
Level of Surgery (I) or (III)

III. INCIDENT INFORMATION

3/3/03
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other

Note: If the incident involved a death, was the medical examiner notified? Yes No
Was an autopsy performed? Yes No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

98 lb pt undergoing submuscular breast augmentation
Found to have extremely small intercostal muscle
& narrow space which lead to small puncture
when muscle was elevated. Small amt free
air entered chest cavity.

B) ICD-9-CM Codes

<u>85.32</u>		<u>51.21</u>
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only _____ Name of facility to which patient was transferred <u>Munroe Regional Medical Center</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
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E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

ME 0039282 - Surgeon Dr Cohen-Shohet

F) List witnesses, including license numbers if licensed, and locating information if not listed above

RN 3344312 - CRNA 079767 - Certified Scrub Tec
RN 9170922 - circulating nurse

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Very small intercostal muscle due to patient size.

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Sent to hospital & kept for observation x 48 hrs.
Treated medically. No need for chest tube.
This is the surgeons only occurrence of this nature in 20 yr

<u>V. W. Aquilino RN, BS, LHRM</u>	<u>5502394</u>
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT	LICENSE NUMBER
<u>3/3/03</u>	<u>1700</u>
DATE REPORT COMPLETED	TIME REPORT COMPLETED

1235



STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE CONSUMER SERVICES UNIT
ADVERSE INCIDENT REPORT

03 MAR 25 AM 7:10

SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14000,
Tallahassee, Florida 32317-4000

I. OFFICE INFORMATION
FI CANCER IN STUF

Name of office
Brookville
City 34 Zip Code HERNANDO County

Name of Physician or Licensee Reporting
Dr. CARAPONNA
24241 KAUFMAN Rd
Patient's address for Physician or Licensee Reporting

Brookville FL
Street Address
352-799-6349
Telephone

License Number & office registration number, if applicable

II. PATIENT INFORMATION



5/10/03 Date of Office Visit
 Medicaid Medicare

Diagnosis:
LUNG CA. E BONE METS

Chemo treatment
Purpose of Office Visit
176.50
ICD-9 Code for description of incident
Level of Surgery (II) or (III)
no procedure

III. INCIDENT INFORMATION

3/11/03 11:20 AM
Incident Date and Time

Location of Incident:
 Operating Rm Recovery Rm
 Other Chemo RA

Note: If the incident involved a death, was the medical examiner notified? Yes No
Was an autopsy performed? Yes No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

pt was admitted for chemo & seen by Dr. CARAPONNA ER 11:20
pt was seen by Dr. CARAPONNA came to the chemo room for treatment.
room was accessed & good blood return pt received premeds Kytrel + Deladron
over 15 minutes, pt said [redacted] felt pressure in the center of [redacted] chest pain scale
8 pt only got premeds no chemo pt was on O2 NIV 3L Alvead, called 911, EMS
came 5 minutes later pt B/P 158/90 P-84 pt was assessed by EMS pain had gone
down to 4 pt was taken to Oak Hill Hospital A&E + talking to EMS staff.

B) ICD-9-CM Codes

058.1
Surgical, diagnostic, or treatment procedure being performed at time of incident
(ICD-9 Codes 01-99.9)

unknown
Accident, event, circumstances, or specific agent that caused the injury or event.
(ICD-9 E-Codes)

786.50
Resulting injury
(ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only <u>ORIENTED OBSERVED STABLE</u> Name of facility to which patient was transferred <u>OAK HILL Hospital</u>	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
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E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

John C Brodman MD RN 227276 NURSE CARLINE FORRY
BARBARA CARA RN RN 601502 HELPER ABOVE ST TO HALLWAY

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

V.

John C Brodman John Brodman
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
3/11/02 1100 AM
 DATE REPORT COMPLETED TIME REPORT COMPLETED

not JCAHO accredited

American Board certified of obstetrics & gynecology

STATE OF FLORIDA
Jeb Bush, Governor



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO: DOH 4052 Blvd Cypress
Agency for Health-Care Administration; BIN C-75
Consumer Services Unit, Post Office Box 14000
Tallahassee, Florida 92017-4000 92394

236

179

Northwest Hospital

NOT AAAHC

no accreditation

I. OFFICE INFORMATION

Name of office: MICHAEL BENJAMIN MD

City: TAMPA State: FL Zip Code: 33621 County: BWD

Name of Physician or Licensee Reporting: MICHAEL BENJAMIN

Patient's address for Physician or Licensee Reporting: NOT KNOWN

Street Address: 2707 N. UNIVERSITY

Telephone: 954-726-7770

License Number & office registration number, if applicable: 14,909

Pregnancy termination -> chromatic fluid embolism death

II. PATIENT INFORMATION

[Redacted Patient Information]

Age: 3/21/03 Gender: [Redacted] Medicaid: [Redacted]

Date of Office Visit: [Redacted]

Purpose of Office Visit: TERMINATION OF PREGNANCY

ICD-9 Code for description of incident: 637.62

Level of Surgery (II) or (III): II

III. INCIDENT INFORMATION

Incident Date and Time: 3/21/03 @ 2:30 PM

Location of Incident: Operating Rm Recovery Rm Other

Note: If the incident involved a death, was the medical examiner notified? Yes No
Was an autopsy performed? Yes No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

SEE ATTACHED

no AAAHC accreditation

CONSUMER SERVICES UNIT

B) ICD-9-CM Codes

635.92
Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

637.62
Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)

518.81
Resulting injury (ICD-9 Codes 800-899.9)

C) List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response)

NONE

D) Outcome of Incident (Please check)

<input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Surgical procedure performed on the wrong patient <input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure <input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital Outcome of transfer - e.g., death, brain damage, observation only <u>DEATH</u> Name of facility to which patient was transferred _____	<input type="checkbox"/> Surgical procedure performed on the wrong site ** <input type="checkbox"/> Wrong surgical procedure performed ** <input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure ** if it resulted in <input type="checkbox"/> Death <input type="checkbox"/> Brain Damage <input type="checkbox"/> Spinal Damage <input type="checkbox"/> Permanent disfigurement not to include the incision scar <input type="checkbox"/> Fracture or dislocation of bones or joints <input type="checkbox"/> Limitation of neurological, physical, or sensory function; <input type="checkbox"/> Any condition that required the transfer outcome of the patient
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E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

MICHAEL BENJAMIN MD 14909

F) List witnesses, including license numbers if licensed, and locating information if not listed above:

ROBBI MATSUMOTO PN 636561 SYDNEY MACAW RN 3185452

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete responses)

ANASTHETIC FLUID EMBOLIZATION (SEE NARRATIVE)

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete responses)

SEE NARRATIVE

V. Michael Benjamin MD 14909
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER
9/2/03 UPM
 DATE REPORT COMPLETED TIME REPORT COMPLETED

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:

DOH
Pin 6-75

presented in my office on March 20, 2003 requesting pregnancy termination. Ultrasound was performed; three laminaria and one dilapan were inserted on that date to ripen and dilate the cervix.

She returned as scheduled on March 21, 2003. She reported no unusual events during the evening. Following a formal discussion of the procedure, the patient was sedated with 5 mg of Versed and 75 mg of Demerol IV through an established line. She tolerated medication well and maintained > 98% O2 saturation with a normal pulse rate.

Approximately ten minutes post-sedation, laminaria were removed. A paracervical block with 10 cc's of 1% lidocaine containing 4 units of Vasopressin was administered. Using a Bierer forceps, membranes were ruptured where they protruded from the os and amniotic fluid drainage begun. Approximately ten seconds into this step, the patient began to cough spasmodically and within seconds was apneic. O2 saturation began to fall and no pulses were detectible. Cardiopulmonary resuscitation including IF fluid loading, Narcan and epinephrine was begun immediately and EMS summoned.

Initial ECG revealed wide complexes. EMS arrived. They continued resuscitative efforts and transported the patient to University Hospital two blocks away. While the patient was en route, I discussed the situation with Dr. Lieberman in the Emergency Room. I advised her that I strongly suspected amniotic fluid embolization.

Dr. Lieberman advised me by telephone approximately 15 minutes later, the patient had expired.

Having reviewed the literature, I reviewed the incident with my staff and concluded that there were no procedural changes that would have altered the event. We concluded that our resuscitative efforts were appropriate and there were no deficiencies in drugs or equipment. I believe, as literature indicates, that amniotic fluid embolization is an unpredictable and unavoidable event which carries the 50 to 90 % mortality reported in the literature. There is no alternate procedure, including delivery at term, which can obviate this risk.

Michael Benjamin MD



PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

63 APR 16 AM 7:44

231
80

SUBMIT FORM TO:
Agency for Health Care Administration,
Consumer Services Unit, Post Office Box 14000,
Tallahassee, Florida 32317-4000

I. OFFICE INFORMATION

Name of office Florida Cancer Institute
City Brooksville Zip Code 34613 County Hernando
Name of Physician or Licensee Reporting Michelle Eger RN

Street Address 11307 Cortez Blvd.

Telephone 1-352-596-1926

License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

no procedure

II. PATIENT INFORMATION

[Redacted Patient Information]

Age 3/19/03 Gender _____ Medicaid Medicare _____

Date of Office Visit _____
Purpose of Office Visit Chemotherapy

Patient Identification Number _____
Diagnosis Breast Cancer

ICD-9 Code for description of incident _____

Level of Surgery (II) or (III) _____

III. INCIDENT INFORMATION

Incident Date and Time 3/19/03 9:23 am

Location of Incident:
 Operating Rm Recovery Rm
 Other _____

Note: If the incident involved a death, was the medical examiner notified? Yes No N/A
Was an autopsy performed? Yes No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Pt was Pt 023. Tolerated chemo pre-meds well. Taxotera 40mg (in 250cc started at the rate of 205 via pump) Approximately 10 min into chemo pt began to cough, vomited sm. amt. of clear emesis. Pt became unresponsive, sitting upright, staring off into the distance. Chemo stopped. Chain moved into hallway, pt positioned on floor. Pt did not stop breathing and had good strong pulse. BP 140/110 @ 9:25, SoluMedrol 80mg at 9:30, BP 170/90 @ 9:35 (pulse 104) Pt was then able to answer basic questions, states "My head hurts." Transferred via EMS to OIH RR.

4403

B) ICD-9-CM Codes

V58.1
Surgical, diagnostic, or treatment procedure being performed at time of incident
(ICD-9 Codes: 01-99.9)

~~158.1~~ 995.2
Accident, event, circumstances, or specific agent that caused the injury or event.
(ICD-9 E-Codes)

Unknown
Resulting injury
(ICD-9 Codes 800-999.9)

C) List any equipment used if directly involved in the incident
(Use additional sheets as necessary for complete response)

D) Outcome of incident (Please check)

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain Damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal Damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure
<input type="checkbox"/> Surgical procedure performed on the wrong patient	** If it resulted in
<input type="checkbox"/> A procedure to remove unplanned foreign objects remaining from surgical procedure	<input type="checkbox"/> Death
<input checked="" type="checkbox"/> Any condition that required the transfer outcome of the patient to a licensed hospital	<input type="checkbox"/> Brain Damage
Outcome of transfer - e.g., death, brain damage, observation only _____	<input type="checkbox"/> Spinal Damage
Name of facility to which patient was transferred <u>Oak Hill Hospital</u>	<input type="checkbox"/> Permanent disfigurement not to include the incision scar
	<input type="checkbox"/> Fracture or dislocation of bones or joints
	<input type="checkbox"/> Limitation of neurological, physical, or sensory function;
	<input type="checkbox"/> Any condition that required the transfer outcome of the patient

E) List all persons, including license numbers if licensed, locating information, and the capacity in which they were directly involved with this incident.

2628182EN

Michelle Eger RN - monitored patient, administered sedation
Roberta Joseph RN (2628182) 2758482 monitored patient

F) List witnesses, including license numbers if licensed, and locating information if not listed above

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

Adverse reaction to Taxotere

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

Patient will not receive Taxotere again.

v. Michelle Eger RN RN 2628182-224901
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

DATE REPORT COMPLETED

TIME REPORT COMPLETED

UAW 4-4-03

238
189



STATE OF FLORIDA
Jeb Bush, Governor

PHYSICIAN OFFICE
ADVERSE INCIDENT REPORT

SUBMIT FORM TO:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

I. OFFICE INFORMATION

Name of office: Florida Hematology and Oncology Center
City: Bradon Fl. Zip Code: 33511 County: Hillsborough
Name of Physician or Licensee Reporting: George Demarkar MD

Street Address: 401 Vanderbilt Dr
Telephone: 813-684-2339
License Number & office registration number, if applicable: _____

Patient's address for Physician or Licensee Reporting: _____

II. PATIENT INFORMATION

[Redacted Patient Information]

Patient Identification Number: _____
Diagnosis: Non Hodgkin's Lymphoma

Age: 4-30-03 Gender: _____ Medicaid: _____ Medicare: _____

Date of Office Visit: _____
Purpose of Office Visit: Blood draw

ICD-9 Code for description of incident: 780.39

Level of Surgery (II) or (III): _____

III. INCIDENT INFORMATION

Incident Date and Time: 4-30-03 1440h.

Location of Incident:

Operating Rm Recovery Rm
 Other: Lab

Recovery Rm

RECEIVED
CONSUMER SERVICES UNIT
04 MAY 12 AM 7:57

Note: If the incident involved a death, was the medical examiner notified? Yes No
Was an autopsy performed? Yes No

A) Describe circumstances of the incident (narrative)
(use additional sheets as necessary for complete response)

Patient arrived under own power to office. While drawing CBC from left arm, patient slumped, became unresponsive, cool clammy to the touch and became stiff & "jerky." Patient briefly roused and then exhibited the same symptoms. EMS called, patient assessed, found to have blood glucose of 118, BP 95/60, sinus rhythm on monitor. Patient did not want to go to ER, office staff insisted and notified patient's friend of occurrence.

101 5-5-03