

NOT Relevant

197



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

RECEIVED  
CONSUMER SERVICES UNIT  
02 AUG 27 AM 1:38

I. OFFICE INFORMATION

Southeastern Urological Center, P.A.  
Name of office

Tallahassee 32308 Leon  
City Zip Code County

W. Paul Sawyer, M.D.  
Name of Physician or Licensee Reporting

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

2000 Centre Pointe Blvd  
Street Address

850-201-0408  
Telephone

ME27104  
License Number & office registration number, if applicable

II. PATIENT INFORMATION



8-12-02 Date of Office Visit

Follow-up visit Purpose of Office Visit

urinary incontinence  
Diagnosis

N/A  
ICD-9 Code for description of incident  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

8/12/02 2:00 p.m.  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Doc. office

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)

while in exam room, patient began to complain of chest pain. Staff started oxygen and gave patient nitroglycerin tablets. Started IV and called Ems. Patient transported to Tallahassee Memorial for further evaluation and treatment by internal medicine / cardiology.

**B) ICD-9-CM Codes**

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

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

N/A  
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>Jallahassee 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
---	--

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

<u>Angie Jougne, RN</u>	<u>Staff nurse</u>	<u>3066282</u>
<u>Jeany Spear, RN</u>	<u>Clinical Services Director</u>	<u>91591-2</u>
<u>W. Paul Sawyer, M.D.</u>	<u>Physician</u>	<u>ME 27104</u>
<u>Kay Novello, RN</u>	<u>Risk manager</u>	<u>5500848</u>

**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)**

Symptoms unrelated to urological diagnosis.

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

Patient evaluated + appropriately transferred to hospital for further evaluation + treatment.

**V. Kay Novello, RN for W. Paul Sawyer, M.D.**

**SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT**      **LICENSE NUMBER**  
8/13/02      10:00 a.m.  
**DATE REPORT COMPLETED**      **TIME REPORT COMPLETED**

198

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

RECEIVED  
CONSUMER SERVICES UNIT  
02 AUG 28 AM 8:04

*Chemo Reaction*  
*Not Relevant*

I. OFFICE INFORMATION

Name of office: Space Coast Medical Associates  
City: Titusville FL 32780 BREVARD County  
Name of Physician or Licensee Reporting: Richard Levine, MD

Street Address: 850 Century Medical Drive  
Telephone: 321-268-4200  
License Number: ME0040927

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

Patient Name: [Redacted]  
Locating Information: [Redacted]  
Patient Identification Number: [Redacted]  
Diagnosis: Nasopharyngeal Lymphoma

Age: 08-16-02 Gender: [Redacted] Medicaid/Medicare: [Redacted]  
Date of Office Visit: [Redacted]  
Purpose of Office Visit: chemotherapy  
ICD-9 Code for Diagnosis: 202.08

III. INCIDENT INFORMATION

Incident Date and Time: 8-16-02 10:45 am

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other physician office

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)

Rituxan 600mg / 500cc NS ordered for infusion. Patient has had rituxan before  
5 incident. Infusion initiated at 1040 - at 1045 pt reported severe low  
back pain - face flushed - BP 164/90 P88. Rituxan infusion stopped -  
normal saline infused - placed on O2 4L/min - patient examined by MD - VS  
monitored q 5 mins - pt re-examined by MD and order received for  
transport to ER at 11<sup>50</sup> AM.

(36)

(37)

B) ICD-9-CM Codes

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)
J9310 - Rituxan / 96410 - Administration of chemotherapy	E933.1 Primary systemic agent - antineoplastic drug	963.1 Poisoning by primary systemic agent - antineoplastic.

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

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 sensory 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. Care of patient.

Terry McFarland RN 9180929 850 Century Medical Drive Titusville FL 32796 phone 321-268-4200	Nora Fetherman RN 1828792 850 Century Medical Drive Titusville FL 32796 phone 321-268-4200
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F) List witnesses, including license numbers if licensed, and locating information if not listed above

AS ABOVE

IV. ANALYSIS AND CORRECTIVE ACTION

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

pt had adverse reaction to Rituxan -  
pt sent to Parrish Medical Center

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

pt was released from Parrish Medical Center  
in satisfactory condition after evaluation in ER

V.

SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT  
8/16/02  
DATE REPORT COMPLETED

430 p 8/16/02  
TIME REPORT COMPLETED

40727  
LICENSE NUMBER



199



STATE OF FLORIDA  
Jeb Bush, Governor

RECEIVED  
CONSUMER SERVICES UNIT  
02 SEP 24 AM 7:58



PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

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

Chemo Resumes

Not relevant

I. OFFICE INFORMATION

Name of office Florida Community Cancer Center

City Brooksville Zip Code 34601 County Hernando

Name of Physician or Licensee Reporting Sharon Robitille MD

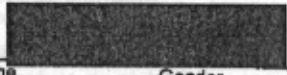
Patient's address for Physician or Licensee Reporting 129 Oak Lane Dr Spring Hill FL 34608

Street Address 11307 Cortez Blvd

Telephone 352-596-1926

License Number & office registration number, if applicable PA 3176322

II. PATIENT INFORMATION



Age \_\_\_\_\_ Gender \_\_\_\_\_  Medicaid  Medicare

Date of Office Visit 9-11-02

Purpose of Office Visit Chemotherapy

ICD-9 Code for description of Incident H20.3 Resp Arrest 518.812

III. INCIDENT INFORMATION

Incident Date and Time 9-11-02 12:15 pm

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Chemo 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)

pt receiving chemotherapy - Gemzar infused 3 difficulty - Carboplatin  
p 5 min = 17.4 mg = pt c/o dizziness and SOB - respiratory arrested  
pt placed on floor - airway obtained and pt then ambu bagged  
x 5 min - wake up when EMS arrived - transported to Oak Hill  
Hospital via EMS where she was admitted.

B) ICD-9-CM Codes

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

518.81  
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"/> 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>admitted</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.

Sharon Robitille RN RN 3176322 - treating nurse  
Barbara Care RN error

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

Barbara Care RN 601502

IV. ANALYSIS AND CORRECTIVE ACTION

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

Allergic reaction to carboplatin - respiratory arrest

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

carboplatin D/d - pt airway maintained - transferred to Oak Hill Hospital via EMS

V. Sharon Robitille RN RN 3176322  
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER

9-11-02  
DATE REPORT COMPLETED

1300  
TIME REPORT COMPLETED

200



STATE OF FLORIDA  
Jeb Bush, Governor

RECEIVED  
CONSUMER SERVICES UNIT  
02 OCT - 1 AM 7:50

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

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

Chemo reaction  
Not NELE/AMT

I. OFFICE INFORMATION

Name of office: Florida Community Cancer Center  
City: Brooksville Zip Code: 34613 County: Hernando  
Name of Physician or Licensee Reporting: Gail D. Egnatuk  
Patient's address for Physician or Licensee Reporting: \_\_\_\_\_

Street Address: 11307 Carter Blvd  
Telephone: (352) 596-1926  
License Number & office registration number, if applicable: 915242

II. PATIENT INFORMATION

Diagnosis: Metastatic Bronchoalveolar carcinoma  
Date of Office Visit: 09/06/02  
Purpose of Office Visit: chemotherapy treatment  
ICD-9 Code for description of incident: \_\_\_\_\_  
Level of Surgery (II) or (III): \_\_\_\_\_

III. INCIDENT INFORMATION

Incident Date and Time: 09/06/02 125m

Location of Incident:  
 Operating Rm  
 Other  
 Recovery Rm

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. slept throughout treatment, productive cough - loose  
whitish sputum. Pt unable to be aroused. Ineffective breathing  
pattern. Mucoid membranes of mouth cyanotic. O2 via  
N/A applied. Suctioned orally. EMS called. Pt transferred  
via stretcher to ambulance to Oak Hill Hospital. Pt's resp. remain  
slow & shallow but pt responding verbally and following  
commands at time of transfer.



B) ICD-9-CM Codes

158.1/162.8  
Surgical, diagnostic or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)

162.8/786.05  
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"/> 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>admitted</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.

Gail D. Egnatuk 915242  
John Brodtman 2729692  
Sharon Robitille 3176372

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)

Pt. medical condition and ineffective breathing pattern

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

O2 via n/c, Suctioned, transfer to Hospital

V.

Gail D. Egnatuk  
SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT  
7-6-02  
DATE REPORT COMPLETED

915242  
LICENSE NUMBER  
4:15 pm  
TIME REPORT COMPLETED



? board cert?  
? hosp cred?  
? accredited?

09/17/04 05:58 FAX 9225038  
CONSUMER SERVICES UNIT

201

BD OF MED

02

02 OCT -1 AM 7:50



STATE OF FLORIDA  
Jeb Bush, Governor

YES Board certified  
BY - GA gastroenterologist  
- NO - Accredited  
Hospa priv only  
@ Pembroke

perforation  
sigmoid colon

Not  
Accredited

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  
GASTROINTESTINAL DIAGNOSTIC CENTERS  
Name of office  
Pembroke Pines 33024 Broward  
City Zip Code County  
Howard A. Rubenstein, MD  
Name of Physician or Licensee Reporting

2245 N. UNIVERSITY DRIVE  
Street Address  
(954) 963-0888  
Telephone  
ME 56649 - Reg # 175  
License Number & office registration number, if applicable

Patient's address for Physician or Licensee Reporting

II. PATIENT INFORMATION



MARCH 22, 2002  
Date of Office Visit  
T. UNDERGO Colonoscopy  
Purpose of Office Visit  
569.83  
ICD-9 Code for description of incident  
II  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

MARCH 22, 2002 9:15 AM  
Incident Date and Time

Location of Incident:  
 Operating Rm  
 Other Endoscopy Room  
 Recovery Rm

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)

The patient after obtaining informed consent was given supplemental oxygen (3L via nasal cannula), sedated with 10mg Valium IV & 1mg Versed IV (given individual doses) and placed in the left lateral decubitus position. The external & digital exam were normal. Next the video colonoscopy was initiated. At 40cm of the left colon a 5-6mm sessile polyp was removed by snare polypectomy technique. A 2mm larger polyp 1.0cm above at 50cm (not removed). The colonoscope then advanced to mid transverse colon. At this point there was noted to be blood oozing out the rectum. The scope was then withdrawn & the underlying mucosa was examined. There appeared to be a perforation at the level of the sigmoid colon. At this point 911 was called & emergency personnel were on their way. The patient was hemodynamically stable (BP 100/60, HR 55, RR 14 O<sub>2</sub> saturation 96%).  
As well as the Emergency Room Physician at Memorial Hospital Pembroke to inform him of the situation.

III

A. Describe circumstances of the incident (narrative continued)

all the while the patient continued to be monitored.  
Arrangements were made for a colorectal surgeon to see the patient at the emergency room. Paramedics arrived and the patient was transported to Memorial Hospital Dubuque, which is just two miles from our office. I contacted the patient's son in [redacted] informing him of the situation and that his [redacted] was being transported to the hospital.

\* The polyp of 50mm of the left colon was planned to be removed at the conclusion of the colonoscopy, because of its size. Owing to the perforation it could not be removed at this time. Also, the polyp initially removed was to be retrieved at the conclusion of the procedure.

Howard A. Rubenstein

B) ICD-9-CM Codes

45378	45378	569.83
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) OLYMPUS CF 100L VIDEO COLONOSCOPE

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 SURGICAL REPAIR Name of facility to which patient was transferred MEMORIAL HOSPITAL PEMBROKE	<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.

HOWARD A. RUBENSTEIN, MD	FL LICENSE ME 0056649	2245 N. UNIVERSITY DR.	PIMMORRE PING, FL 33024
NORA KELLY, RN	FL LICENSE 74588-2	" "	SAME " " " "
SARI DAUNPORT	GI. TECH	" "	SAME " " " "

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)

TEAR IN RECTUM FROM COLONOSCOPE. THIS LIKELY OCCURRED FROM TORQUING THE COLONOSCOPE THE TEAR WAS NOT AT THE LEVEL OF THE POLYPECTOMY SITE (IT IS NOT UNUSUAL TO TORQUE THE COLONOSCOPE IN PERFORMING COLONOSCOPY)

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

THE PATIENT WAS SENT TO MEMORIAL PEMBROKE HOSPITAL. HERE UNDERWENT SURGICAL REPAIR OF THE TEAR BY PRIMARY ANASTOMOSIS (NOT REQUIRING COLOSTOMY) BY THE COLORECTAL SURGEON.

V.

Howard A. Rubenstein ME 0056649  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER  
 09-20-02 2:00 PM.  
 DATE REPORT COMPLETED TIME REPORT COMPLETED



202



Conway  
recovery



N/A

STATE OF FLORIDA  
Jeb Bush, Governor

RECEIVED  
CONSUMER SERVICES UNIT  
02 OCT -7 AM 7:49

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 Watson Clinic  
City Lakeland Zip Code 33801 County Polk  
Name of Physician or Licensee Reporting Dr. Guttuso RN  
same  
Locating Information for Physician or Licensee Reporting

Street Address 11000 Lakeland Hills Blvd  
Telephone 813-680-7000  
License Number 1751902

II. PATIENT INFORMATION

[Redacted Patient Information]

[Redacted Patient Information]  
Date of Office Visit 9.18.02  
Purpose of Office Visit  
ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

Incident Date and Time 9/18/02

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other CT scan

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 arrived to CT scan pt injected 125cc Optiva 350  
8:05 - Pt. states [redacted] felt warm + became unresponsive  
Blue team called immediately after Code 99 called.  
Code Team + Dr. Eckelburg + Dr. Guttuso responded  
CPR in progress through out code - Meds 5ml Medrol  
Tagamet, Benedryl + .50 mg Epi given via IV  
Monitor applied 8:05 on pt until D/C then on  
EMS monitor - EMS intubated + shocked pt upon  
arrival Rhythm 147 No palpable pulses.



B) ICD-9-CM Codes

CAT SCAN Follow up  
given

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"/> 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 of the patient to a licensed hospital	<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 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.

Pat Cardin ARNP 306902 RN 1699652 Brenda Entekin ME 81774 Dr. Giustusso  
 Karla Glottelty 2600102 Ronda Riley RT/ARRT 185748 General Rad. 21212  
 Bunny Grappuso 1751902 Melissa Kelly  
 Appie Howell RN 1467812 Dr. Eckelberg ME 81774 ME 16987  
 Lt Tech General Rad. 47653

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)

possible reaction to opt ray injection successfully coded to rhythm - pulse ST tube in place at ambu - O2

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

V. [Signature]  
 SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT  
 9/18/02  
 DATE REPORT COMPLETED

ME 16937  
LICENSE NUMBER

9:50 a  
TIME REPORT COMPLETED

203

1. insert of catheter - SOB -> concluded  
to ec. No incident occurred



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

RECEIVED  
CONSUMER SERVICES UNIT  
02 OCT - 9 AM 7:57

Not relevant

I. OFFICE INFORMATION

Southeastern Urological Center, P.A.  
Name of office

2000 Centre Pointe Blvd  
Street Address

Tallahassee 32308 Leon  
City Zip Code County

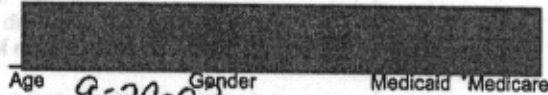
850-201-0468  
Telephone

Joseph X. Camps, M.D.  
Name of Physician or Licensee Reporting

ME57214  
License Number & office registration number, if applicable

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

II. PATIENT INFORMATION



Prostate Cancer  
Patient Identification Number  
Diagnosis

9-27-02 Gender Male Medicaid/Medicare  
Date of Office Visit  
Irrigation of urinary catheter  
Purpose of Office Visit

N/A  
ICD-9 Code for description of incident  
Level of Surgery (II) or (III)

III. INCIDENT INFORMATION

9-27-02 9:45 a.m.  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Dr's office

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 came to office for irrigation of urinary catheter. Has pacemaker and AICD. Became increasingly short of breath while in office. Office staff notified patient's cardiologist and called EMS. Patient transferred to Tmt E.R. for further evaluation and treatment by cardiologist.

02 OCT -9 AM 7:52  
PHYSICIAN SERVICES UNIT

B) ICD-9-CM Codes

<u>N/A</u>	<u>N/A</u>	<u>N/A</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>Gallahassie 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
---	--

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

<u>Byron Blasko, ARNP</u>	<u>ARNP 1554842</u>
<u>Mary-Jord, RN</u>	<u>8070262</u>
<u>Joseph L. Camps, M.D.</u>	<u>ME 57214</u>

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)  
Patient had known cardiac condition. Symptoms unrelated to patient's urological 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 in E.R.

v. Hayemorello, RN for J.L. Camps, M.D. 5500848/ME 56136  
 SIGNATURE OF PHYSICIAN/LICENSÉE SUBMITTING REPORT      LICENSE NUMBER  
10-1-02      11:15 a.m.  
 DATE REPORT COMPLETED      TIME REPORT COMPLETED



204

*Chemotherapy*



*2013*

STATE OF FLORIDA  
Jon Bush, Governor

PHYSICIAN OFFICE  
ADVERSE INCIDENT REPORT

*NOT RELEVANT*

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

RECEIVED  
CONSUMER SERVICES UNIT  
02 OCT 16 AM 7:48

I. OFFICE INFORMATION

Northwest Oncology ~~9100~~ ~~Wests~~

Cardi Springs 33065 Blvd  
City Zip Code County

Dr Steven Weiss  
Name of Physician or Licensee Reporting

8170 Royal Palm Blvd  
Street Address

(954) 755-1904  
Telephone

ME057847  
License Number

Locating Information for Physician or Licensee Reporting

II. PATIENT INFORMATION

Locating Information

Patient Identification Number

Diagnosis

Age Gender  Medicaid  Medicare

Date of Office Visit

Purpose of Office Visit

ICD-9 Code for Diagnosis

III. INCIDENT INFORMATION

9-27-02 11 AM  
Incident Date and Time

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other Outpt Office

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

*NIA*

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

*Pt "re-challenged" with Wk # 2 of Carboplatin (Pt known to have sensitivity to this drug in past but able to tolerate p being pretx & ↑ doses of Steroids). Decadron 10mg IV + Solu-cortef 100mg IV + Cincumet 100mg IV pre carbo given. (120mg of Carboplatin in 200cc NS) & ran 11cc (20mg) when pt became red faced, eyes bloodshot, restless, ↑↑ diaphoretic, Bp ↓ to 80 palpable, Paraplatin stopped, IV NS wide open, Trendelenberg, Solu-Cortef 50mg NP + Benadryl 20mg NP for severe "itching". Fingers blue, intermittent tremors/rigors. Coughing but lungs clear. Bp recovered, O2n dry. Still red faced, tongue "thick". Fingers still blue... 911 → CS MC →*  
*Approx: 1230/p → discharged approx 430/pm*



B) ICD-9-CM Codes

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"/> 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 of the patient to a licensed hospital	<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 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.

Ana Marie Singh TN29698. Lab Person  
 Mary Fifeild RN735212 Chemo RN OCA  
 Dr Steven Weiss MD ME057847

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

MARY FIFEILD RN735212 - Chemo Nurse

IV. ANALYSIS AND CORRECTIVE ACTION

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

Sensitivity / allergic Reaction to Carboplatin -> then became Extrapyramidal due to Steroids + Benadryl.

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

Change Chemo drug from Carboplatin to another drug

V. Steven Weiss SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING REPORT LICENSE NUMBER 57847

DATE REPORT COMPLETED 9/30

TIME REPORT COMPLETED 3 PM

205



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

RECEIVED  
CONSUMER SERVICES UNIT  
02 OCT 30 AM 7:32

1 row  
infusion  
low hemoglobin

NOT RELEVANT

I. OFFICE INFORMATION

Name of office FCCC / SCC  
City SCC Zip Code 33573 County Hills  
Name of Physician or Licensee Reporting Dr. George Dermerker  
Locating Information for Physician or Licensee Reporting

Street Address 11031 Under Creek Dr.  
Telephone 813-633-2733  
License Number ME 0002547

II. PATIENT INFORMATION

Patient Name [Redacted]  
Age 10-9-02 Gender [Redacted] Medicaid/Medicare [Redacted]  
Date of Office Visit 10-9-02  
Purpose of Office Visit IRM infusion  
Diagnosis iron def. anemia w/ renal failure  
ICD-9 Code for Diagnosis 280.9 w/ 58.5.0

III. INCIDENT INFORMATION

Incident Date and Time 10-9-02 @ 12:20pm

Location of Incident:  
 Operating Rm  Recovery Rm  
 Other facility

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 presented for tx to % severe weakness & SOB. IV started & NS infusing. Labs drawn (Hgb 5.4) Pt restless. Benadryl 25mg IV PB given. Iron infusion started. Pt continued to restlessness. Halfway into iron infusion restlessness T & D (no pain) Iron stopped NS infusing ARNP & Dr. present Benadryl 25mg IVP & Decadron 10mg IVP given. Emergency Squad called to transport pt to SBH J 98' P 58' B/P 130/76  
Pt stated [Redacted] had been restless x 2 wks.

10/27/02