GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Healthcare Facility Regulation Division
Health Care Section, Diagnostic Services Unit
2 Peachtree Street, N.W. Suite 31-447
Atlanta, Georgia 30303
Tel: 404.657.5450 Fax: 404.657.5442

REQUIRED LABORATORY SELF REPORTS

(Please Type Form)

FACILITY INFORMATION

Name of Laboratory:_____**License #:**_____

Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Person Reporting Incident: _____**Title:**_____

Contact Person(s): _____ **Phone Number of Contact:**_____

Fax #: _____**Email Address:**_____

Patient /Reporting Information

Date_____ **Time** _____ **a.m./p.m.** **Incident Occurred**

Date_____ **Time** _____ **a.m./p.m.** **Facility was aware that reportable incident may have occurred**

Date_____ **Time** _____ **a.m./p.m.** **Reported to HFRD**

COMPLETE IF APPLICABLE

_____	_____	_____M/F	_____
Patient Name	**Age**	**Sex**	**Date of Birth**

_____	_____	_____
Medical Record #	**Date of Admission**	**Reason for Admission**

Diagnosis *(all)*: (Use Narrative Format, Not ICD-9 Coding)

_____

_____

_____

***Type of Incident*: Please check appropriate boxes.** (Attach a copy of incident report if applicable)

[ ] Fatal transfusion reactions or transfusion complications affecting the patient(s)
[ ] Laboratory testing errors which have resulted in the death or serious injury to a patient or employee
[ ] Significant interruptions in service vital to continued safe operation, such as the loss of electricity, gas or water services

Briefly describe circumstances of the incident: *(attach additional sheet if necessary)*

Immediate Corrective or Preventative Action Taken: (*attach additional sheet if necessary)*

_____
_____
_____
_____
_____
_____

Note: If the incident involved a death, was the medical examiner notified? [ ]Yes [ ] No
Was an autopsy requested? [ ] Yes [ ] No
Name and contact number of Medical Examiner_____

Additional Required Reports: Please check appropriate boxes
The Lab shall make a report of the event within 24 hours or by the next regular business day from when the reportable event occurred or from when the Lab has reasonable cause to anticipate that the event is likely to occur.

Acknowledgement of Information Reported:

I certify that the information reported within this form is true, accurate and completed to the best of my knowledge.

_____ _____ _____
Signature of Person Completing Form ***Title*** ***Date Completed***

_____
Print Name

For Department Use Only

Received in S/A Date:_____

Reviewed By:_____

Date:_____

Reporting time frame of 24 hours/next business day met? ( ) Yes ( ) No

Action Require ( ) Yes ( ) No

Self Report ID #: _____ Complaint Number: _____

This report is required as set forth in the Laboratory Rules §290-9-8.27(6) and must be submitted to the Department within twenty-four (24) hours or by the next regular business day from when the incident occurred, or from when the facility has reasonable cause to suspect a reportable incident §290-9-8-.27(6)