#### GEORGIA DEPARTMENT OF COMMUNITY HEALTH HEALTH CARE FACILITY REGULATION DIVISION HEALTH CARE SECTION 2 Peachtree Street, N.W. Suite 31-445 Atlanta, Georgia 30303 Tel. 404-657-5550 Fax 404-657-8934

# **REQUIRED ESRD SELF REPORTS**

(Please Type Form)

## FACILITY INFORMATION

Nome of Equility						
Name of Facility:						
Facility Type:			Licen	se#:		
Address:						
City:			State:	Zip Code:		
Person Reporting Incident:				Title:		
Contact Person(s):			Phone	Phone Number of Contact:		
Fax#:	Email Address:					
	PATI	ENT/REP	ORTING INFOR	MATION		
Date	Time	a.m./p.m. Reported to HFRD Agency				
Date reportable incident		a.m./p.m. ESRD Facility Was Aware that				
•	•		a.m./p.m. Incident Occurred			
	M/F					
Patient Name		Age	Sex	Date of Birth		
Medical Record #		Date of Admission		Date Dialysis Started		
Diagnosis <i>(all)</i> :		se narrative	format, not ICD-9	coding)		
	(0.			county,		

Patients Current Condition: (check one) [] Dialyzing in center [] In Hospital [] Deceased

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

[] Death

- [] Serious Injury/malfunction of equipment
- [] Exsanguination at facility
- [] Use of another patient's dialyzer
- [] Deviation in patient's prescription
- [] Sexual/Physical assault of patients

### Page 2- ESRD Incident Reporting Form

Briefly describe	circumstances	of the	incident:	(attach additional	sheet if necessarv)
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#### CATEGORY OF STAFF INVOLVED IN THE INCIDENT (check all that apply)

[] Attending MD [] MD Resident [] LPN [] RN [] PA [] NP [] SW [] Dietician

[ ] Trainee (specify type) \_\_\_\_\_ [ ] PCT (specify type) \_\_\_\_\_

[ ] Other (specify type)

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 \_\_\_\_\_

Acknowledgement of Information Reported:

I swear that the information reported within this form is true and 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 D	Date:	
	Reviewed By:		
	Date:		
	Reporting time fra	ame of 24 hours met:()Yes()No	,
	Action Require (	)Yes ()No	
	Self Report ID#	Complaint #	

This report is required as set forth in the ESRD Rules §290-9-9-07(c) 1 through §290-9-9-07(c) 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 the facility has reasonable cause to suspect a reportable incident §290-9-0.7(d).