**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. 404-657-5850 Fax 404-657-8934

# REQUIRED HOSPICE SELF REPORTS

**(Please Type Form)**

## FACILITY INFORMATION

**Name of Facility:** _____

**Facility Type:** _____ **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. Reported to HFRD Agency**

**Date** _____ **Time** _____ **a.m./p.m. Hospice Facility Was Aware that reportable incident may have occurred**

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

| _____ | _____ | _____**M/F** | _____ |
|---|---|---|---|
| **Patient Name** | **Age** | **Sex** | **Date of Birth** |

| _____ | _____ | _____ |
|---|---|---|
| **Medical Record #** | **Date of Admission** | **Date Hopsice Started** |

**Diagnosis *(all)*:** _____

**(Use narrative format, not ICD-9 coding)**

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**Patients Current Condition: (check one)** **[ ] In hospice care [ ] In Hospital [ ] Deceased**

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

**[ ] Death not related to terminal illness [ ] Rape when hospice employee or volunteer at home [ ] Patient assault, abuse or neglect [ ] Serious injury resulting from the malfunction or misuse of patient care equipment [ ] Patient missing more than 8 hours and they or other's health, safety, or welfare is at risk**

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

**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 Date:**_____

**Reviewed By:** _____

**Date:** _____

**Reporting time frame 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-.07(d).**