1. What is being reported?

☐ Sentinel Event
☐ Near Miss

2. Today’s Date: __________________________
   Date of Discovery: ________________________
   Date of Event: ____________________________
   Time of Event: ____________________________ AM/PM
   Date of Death (if applicable): ________________

3. Patient Age: _____ ☐ M ☐ F   Admitting Diagnosis: ______________________________

4. Briefly describe the event including location:

   __________________________
   __________________________
   __________________________
   __________________________
   __________________________

5. What type of event is being reported?

☐ Unanticipated Death
☐ Unanticipated Perinatal Death
☐ Unanticipated Death within 48 Hrs. of Treatment
☐ Suicide within 48 Hrs. of Discharge
☐ Major Permanent Loss of Function in perinatal infant
☐ Major Permanent Loss of Function present at discharge
☐ Major Permanent Loss of Function within 48 Hrs. of Treatment

6. Unanticipated patient transfer to another facility? ☐ Y ☐ N

7. Does this event meet NQF criteria? ☐ Y ☐ N (If yes, continue on back – check all that apply)

8. Autopsy Requested ☐ Y ☐ N   Autopsy Performed ☐ Y ☐ N
   Medical Examiner Called ☐ Y ☐ N   Medical Examiner Accepted Case ☐ Y ☐ N

9. Was equipment e.g., IV pump, medication vials, sequestered? ☐ N/A ☐ Y ☐ N Specify: ______

10. Facility Name: __________________________
    Reporter’s Name: _________________________ Title: __________________________
    Telephone Number: _________________________ E-mail Address: ________________________

State notification of a Sentinel Event is required within one (1) business day of discovery.
Do not delay notification, for any reason, including pending autopsy or Medical Examiner results.

SENTINEL EVENT CONFIDENTIAL FAX (207) 287-3251

This information is protected from public disclosure
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## Surgical or Invasive Events

- Surgery or other invasive procedure performed on the wrong site
- Surgery or other invasive procedure performed on the wrong patient
- Wrong surgical or other invasive procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- Intraoperative or immediately postoperative/post-procedure death in an American Society of Anesthesiologists Class I patient

## Product or device events

- Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used for functions other than as intended
- Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

## Patient Protection Events

- Discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person
- Patient death or serious injury associated with patient elopement (disappearance)
- Patient suicide, attempted suicide or self-harm resulting in serious injury, while being cared for in a healthcare setting

## Care management events

- Patient death or serious injury associated with a medication error (eg, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Patient death or serious injury associated with unsafe administration of blood products
- Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- Stage 3 or 4 pressure and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
- Artificial insemination with the wrong donor sperm or wrong egg
- Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- Patient death or serious injury resulting from failure to follow up on or communicate laboratory, pathology or radiology test results

## Environmental Events

- Patient or staff death or serious injury with an electric shock in the course of a patient care process in a healthcare setting
- Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or is contaminated by toxic substances
- Patient or staff death or serious injury associated with a burn incurred from any source while being cared for in a healthcare setting
- Patient death or serious injury associated with the use physical restraints or bedrails while being cared for in a healthcare setting

## Radiologic Events

- Death or serious injury of a patient or staff associated with the introduction of a metal object into the MRI area

## Potential Criminal Events

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient/resident of any age
- Sexual abuse/assault on a patient or staff member within or on the grounds of the healthcare setting
- Death or serious injury of a patient or staff member resulting from a physical assault (ie, battery) that occurs within or on the grounds of the healthcare setting