Adverse Incident Report
for Planned Out-of-Hospital Births
Florida Department of Health

Submit form to:
Department of Health, Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275

Part I: Practitioner Information

Section 456.0495, Florida Statutes, requires an adverse incident, defined as an event associated with a planned out-of-hospital birth over which a physician licensed under Chapter 458 or Chapter 459, a nurse midwife certified under part I of Chapter 464, or a midwife licensed under chapter 467 could exercise control, to be reported to the Department of Health within 15 days of the incident. Adverse incidents include maternal death; maternal hemorrhagic shock or transfusion; fetal or newborn death including a stillbirth; certain traumatic physical or neurological birth injuries; or a transfer of a newborn to a neonatal intensive care unit under specific circumstances. This form does not replace any other adverse incident report required by the statutes and rules governing your specific profession.

Practitioner Name: ____________________________________________
License Number: _____________________________________________

Part II: Adverse Incident General Information

Incident Date: __________________________ Incident Time: __________________________
Address where incident occurred:__________________________________________
City: __________________________ State: ____________ ZIP: ________________

This address is a:

☐ Home/Private Residence
☐ Physician’s Office
☐ Birthing Center (specify name): ____________________________________________
☐ Other (please specify): ____________________________________________________

Please check all that apply:

☐ A maternal death occurred during delivery.
☐ A maternal death occurred within 42 days after delivery.
☐ The maternal patient was transferred to a hospital intensive care unit.
☐ The maternal patient experienced hemorrhagic shock.
☐ The maternal patient required a transfusion of more than 4 units of blood or blood products.
☐ A fetal or newborn death occurred.

☐ Y ☐ N The fetal or newborn death was a stillbirth.
☐ The newborn was transferred to neonatal intensive care due to a traumatic physical or neurological birth injury.

☐ Y ☐ N This transfer occurred due to a brachial plexus injury.
The newborn was transferred to a neonatal intensive care unit within the first 72 hours after birth and remained in the unit for more than 72 hours.

Part III: Adverse Incident (Narrative Summary)

Describe the circumstances of the incident; use additional sheets as necessary.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Part IV: Patient Identification

Patient Name: ___________________________________________________________

Patient Address: ______________________________________________________________________________________

City: ___________________________ State: _______________ ZIP: _______________________

Part V: Practitioner Signature

Practitioner Signature ___________________________ Date/Time Report Completed ___________________________