Notice of Adverse Healthcare Incident

for Early Discussion and Resolution

Need help?
Call us.
503-928-6158
Toll free: 1-855-470-4079

Instructions: Complete all fields as instructed. Your notice can be accepted only if it is complete.

1 Are you the patient?

☐ Yes →

☐ No ↓

If "No," complete the section below. If "Yes," proceed to section 2.

Why are you filing this notice for the patient?
Check all that apply. A patient's representative can file a notice on behalf of a patient ***only if*** the patient is under the age of 18, has died, or the patient's doctor determined that the patient is incapable of making decisions.

- ☐ The patient is under the age of 18 (unless emancipated)
- ☐ The patient has died
- ☐ The patient's doctor determined that the patient is incapable of making decisions
- ☐ None of the above → Stop. You cannot file this notice.

What is your relationship to the patient?
The only person who can represent the patient and file a notice is the person highest on the list who is both willing and able.

Please check which is true.

- ☐ I am the guardian authorized for healthcare decisions
- ☐ I am the spouse
- ☐ I am the parent
- ☐ I am an adult child (who represents a majority of the patient's adult children who can be located)
- ☐ I am an adult sibling (who represents a majority of the patient's adult siblings who can be located)
- ☐ I am an adult friend
- ☐ I am a person appointed by a hospital
- ☐ None of the above → Stop. You cannot file this notice.

☐ I understand that I can only file this notice if I am the person highest on the list who is both willing and able.

Please provide your contact information.

Name _____
First Last

Address _____
Street Suite, Apt #, etc.

_____
City State Zip code

Phone _____

Email _____
Optional

2 What happened?

When did this incident happen?
If you are uncertain of the specific date or if the incident occurred over the course of more than one day, please provide the date range. If the incident happened on one specific date, write in the begin date only.

Begin date _____ mm/dd/yyyy →

End date _____ mm/dd/yyyy

Dates must be on or after ***July 1, 2014***.

Please briefly describe the incident.
Please do not use any names to describe the incident. If you want to refer to a specific provider, please use general terms (for example, use doctor or nurse 1 and nurse 2). If you want to name a specific provider, please do so in section 5. If you need more space, please include a separate sheet of paper with your brief description.

3 Who is the patient?

Please enter the patient's information below. If the incident involved an unborn or newborn child, please enter the mother's information. If you are the patient's representative, complete all patient information below except address, phone, and email.

Patient's name

First Last MI

Address

Street Suite, Apt #, etc.

City State Zip code

Phone

Email

Optional

Patient's date of birth

mm/dd/yyyy

Patient's gender
Please check the patient's self-identified gender.

- ☐ Male
- ☐ Female
- ☐ Other

If "Other," please specify.

Would you like a language interpreter for the Early Discussion and Resolution process?

- ☐ Yes → **For what language would you like an interpreter?**
- ☐ No

4 Where did this incident take place?

Please complete the location information below.

Check one.

- ☐ Hospital
- ☐ Nursing home
- ☐ Ambulatory surgery center
- ☐ Freestanding birthing center
- ☐ Outpatient renal dialysis center
- ☐ Doctor's office (see section 5)
- ☐ Other (see section 5)

If "Other," please describe.

Name of location

Address

Street Suite, Apt #, etc.

City State Zip code

Phone

5 Who were the involved providers?

If you checked "Doctor's office" or "Other" in section 4, you must identify at least one involved healthcare provider in this section. If the incident happened in one of the other locations listed, you can skip section 5.

You can name two providers below. If you want to name more than two providers, please include a separate sheet of paper with the information requested below for each additional provider.

Provider profession options
Use this list to tell us the profession of each named provider.

Audiologist	Nurse practitioner
Chiropractor	Occupational therapist
Dental hygienist	Optometrist
Dentist	Pharmacist
Denturist	Physical therapist
Direct entry midwife	Physician assistant
Doctor	Podiatric physician
Emergency medical service provider	Podiatric surgeon
Marriage and family therapist	Professional counselor
Massage therapist	Psychologist
Medical imaging licensee	Registered nurse
Naturopathic physician	Speech-language pathologist

Provider 1

Name

First Last

Profession

Choose from the provider profession options above.

Address

Street Suite, Apt #, etc.

City State Zip code

Phone

Provider 2

Name

First Last

Profession

Choose from the provider profession options above.

Address

Street Suite, Apt #, etc.

City State Zip code

Phone

Thank you. Mail your completed notice to:
Oregon Patient Safety Commission, Attn: Early Discussion and Resolution
PO Box 285, Portland, OR 97204

We will share this information with:

1. The location you name in section 4 ***only if*** you check hospital, nursing home, ambulatory surgery center, freestanding birthing center, or outpatient renal dialysis center.
2. Any healthcare providers you name in section 5.