

**Intentional Unsafe Act  
Report**

Submit no later than (7) seven calendar days  
following a good faith belief that intentional unsafe act occurred

**Please complete all sections of this form by printing or typing the required information. The form must be submitted to the Patient Safety Surveillance & Improvement System via secure email, fax or mail. See last page of form for contact information.**

**1. Facility Identification**

Facility name: \_\_\_\_\_

Facility address: \_\_\_\_\_

(Street)

(City)

(State)

(Zip)

Name and title of person submitting report: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email address: \_\_\_\_\_

**2. Employee Information**

Full name of staff person involved with unsafe act: \_\_\_\_\_

**3. Patient Information**

Patient name: \_\_\_\_\_

If a child, parent name(s): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary diagnosis: \_\_\_\_\_

Secondary diagnosis: \_\_\_\_\_

*If more than one patient was involved, complete the following. If additional patients were involved, attach a separate page with the patient information included.*

Patient name: \_\_\_\_\_

If a child, parent name(s): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary diagnosis: \_\_\_\_\_

Secondary diagnosis: \_\_\_\_\_

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**4. Incident Information**

Incident date: \_\_\_\_\_ Time: \_\_\_\_\_

Date you became aware of event: \_\_\_\_\_ Time: \_\_\_\_\_

Date reported to Vermont Department of Health: \_\_\_\_\_

Where was the patient when event occurred? (*Check only one*)

- Unit Medical
  - Surgical
  - ICU
  - Obstetrics/Gynecology
  - NICU
  - Nursery
  - Pediatric
  - Other
- Diagnostic services – specify:
- Dialysis
- Emergency Department
- Labor and Delivery
- Operating Room
- Recovery Room
- Rehabilitative Services – specify:
- Outpatient Services – specify:
- Hallway or other common area
- Other

**5. Understanding of event**

**6. How was event discovered? (*check all that apply*)**

- Reported by staff
  - Nurse Physician
  - Unlicensed staff
  - Other

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- Assessment of patient after event
- Report by family/visitor
- Review of chart/record
- Report by patient
- Other:

**7. Outcome of event** (*check only one*)

- Death; date of death:
- Serious bodily injury – bodily injury that creates substantial risk of death or that causes substantial loss or impairment of function of any bodily member or organ or substantial impairment of health or substantial disfigurement.
- Temporary harm, higher level of care required.
- Temporary harm, increased monitoring required.
- No harm, increased monitoring of patient required.
- No harm, no increased monitoring needed.
- Near Miss – event could have caused an adverse event but did not harm patient.

**8. Patient/family disclosure:**  Yes  No

Date of notification:

If no disclosure, why?

**9. Categorization of event** (*check all that apply*)

- Alleged criminal act
- Alleged purposefully unsafe act
- Alleged alcohol or substance abuse
- Alleged patient abuse

**10. Was the event reported to another agency?**

- Yes (*check all that apply*)
  - Adult Protective Services

Date reported:

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- |                          |                                      |                |
|--------------------------|--------------------------------------|----------------|
| <input type="checkbox"/> | Department for Children and Families | Date reported: |
| <input type="checkbox"/> | Law Enforcement                      | Date reported: |
| <input type="checkbox"/> | Medical Practice Board               | Date reported: |
| <input type="checkbox"/> | Office of Professional Regulation    | Date reported: |
| <input type="checkbox"/> | Other, specify:                      | Date reported: |
| <input type="checkbox"/> | No                                   |                |

**11. Is this event also reportable adverse event?**

- Yes – Complete Reportable Adverse Event initial report form  
 No

**You may email, fax or mail the completed form to the Patient Safety Program.**

**Email form to:** [sre@vpqhc.org](mailto:sre@vpqhc.org)

**Fax form to:** Vermont Program for Quality in Health Care, Inc.  
802-262-1307  
Attention: Patient Safety Program

**Mail form to:** Vermont Program for Quality in Health Care, Inc  
Attention: Patient Safety Program  
132 Main Street  
Montpelier, VT 05602