

PATIENT MOVEMENT EVENT/NEAR MISS REPORT

*(Information placed on this form is confidential and privileged in accordance with 10 U.S.C. 1102.
Do not file or refer to this form in a patient record.)*

PRIVACY ADVISORY: When completed, this form contains personally identifiable information and personal health information and should be protected in accordance with DoD 5400.11-R (the DoD Privacy Program).

Prepare this form to document events that resulted in or had the potential to result in harm to anyone in the PM system.

NOTE: If completed by ASF or other MTF staff follow local MDG incident reporting policy in addition to completing this form.

SECTION I - PERSON COMPLETING FORM

1.a. LAST NAME		b. FIRST NAME		c. MIDDLE INITIAL
d. GRADE	e. UNIT OF ASSIGNMENT			
f. TELEPHONE NUMBER <i>(Include area code)</i>	g. EMAIL ADDRESS		h. SIGNATURE	
i. WITNESSES TO EVENT				
(1) NAME/GRADE	(2) UNIT OF ASSIGNMENT OR ADDRESS	(3) TELEPHONE	(4) EMAIL ADDRESS	
j. PMQ-R GENERATED LOG NUMBER <i>(For PM Safety Manager):</i>				

SECTION II - GENERAL INFORMATION

2. DATE (YYYYMMDD) TIME (Z) OF EVENT	3. LOCATION OF EVENT <i>(Be specific)</i>			
	a. MTF:	d. EN ROUTE HOLDING AREA:	g. AIRCRAFT <i>(In-flight):</i>	
	b. ASF/ASTS:	e. GROUND TRANSPORT:	h. OTHER:	
c. OTHER RON:		f. AIRCRAFT <i>(Ground):</i>		
4.a. MAJCOM RESPONSIBLE FOR MISSION		b. SUBMITTING UNIT		
5. DID THIS EVENT RESULT IN DEATH, NEAR DEATH OR HOSPITALIZATION? <i>(X appropriate block)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO				
6. PERSON AFFECTED OR POTENTIALLY AFFECTED BY THIS EVENT <i>(X appropriate block)</i>				
<input type="checkbox"/> PATIENT	<input type="checkbox"/> PAX	<input type="checkbox"/> CREW	<input type="checkbox"/> FACILITY STAFF	<input type="checkbox"/> ATTENDANT <input type="checkbox"/> CCATT MEMBER
7. EVENT CATEGORY <i>(X as applicable)</i>				
a. MEDICATION <input type="checkbox"/> MEDICATION ERROR <input type="checkbox"/> NARCOTIC NOT ACCOUNTED FOR <input type="checkbox"/> SELF MEDICATION ISSUE <input type="checkbox"/>				
b. STATUS CHANGE				
<input type="checkbox"/> AE PROTOCOL USED	<input type="checkbox"/> DEATH IN-FLIGHT	<input type="checkbox"/> SEIZURES		
<input type="checkbox"/> ALLERGIC REACTION	<input type="checkbox"/> DEATH WITHIN 24 HOURS	<input type="checkbox"/> SHORTNESS OF BREATH		
<input type="checkbox"/> BIRTH	<input type="checkbox"/> DESATURATION	<input type="checkbox"/> SUICIDE		
<input type="checkbox"/> CARDIAC/RESPIRATORY ARREST	<input type="checkbox"/> MEDICATION RESPONSE	<input type="checkbox"/> TRANSIENT/MILD STATUS CHANGE		
<input type="checkbox"/> CHEST PAIN				
c. PATIENT PREP				
<input type="checkbox"/> ATTENDANT ISSUES	<input type="checkbox"/> MEDICATION	<input type="checkbox"/> SUPPLIES		
<input type="checkbox"/> DOCUMENTATION OF CARE	<input type="checkbox"/> ORDERS	<input type="checkbox"/> TREATMENT NOT DONE PRIOR TO FLIGHT		
<input type="checkbox"/> EQUIPMENT	<input type="checkbox"/> PAPERWORK			
d. OTHER				
<input type="checkbox"/> AIRCRAFT AMPERAGE	<input type="checkbox"/> COMMUNICATION	<input type="checkbox"/> NO MEALS SUPPLIED		
<input type="checkbox"/> AIRCRAFT EMERGENCY	<input type="checkbox"/> FLIGHT CREW EQUIPMENT/MSN DUTY	<input type="checkbox"/> PMRC		
<input type="checkbox"/> AIRCRAFT MAINTENANCE DELAY	<input type="checkbox"/> INDIVIDUAL BODY ARMOR	<input type="checkbox"/> TRANSPORTATION ISSUES		
<input type="checkbox"/> BAGGAGE ISSUES	<input type="checkbox"/> MEDICAL DELAY			
e. PATIENT HANDOFF <input type="checkbox"/> INADEQUATE PATIENT HANDOFF <input type="checkbox"/> NO PATIENT HANDOFF				
f. INFECTION CONTROL <input type="checkbox"/> BLOOD OR OTHER BODY FLUID EXPOSURE <input type="checkbox"/> TRANSPORTATION OF INFECTIOUS PATIENT				
g. ASF/RON SPECIFIC <input type="checkbox"/> ASF/RON TRANSPORTATION ISSUES				
h. ANTI-HIJACK <input type="checkbox"/> COMPLETED INCORRECTLY <input type="checkbox"/> NOT COMPLETED				
i. INJURY <input type="checkbox"/> ACTUAL <input type="checkbox"/> POTENTIAL				
j. EQUIPMENT				
TYPE OF EQUIPMENT			MODEL NUMBER/SERIAL NUMBER <i>(If applicable)</i>	
<input type="checkbox"/> NOT APPROVED FOR FLIGHT	<input type="checkbox"/> WAIVER REQUIRED	<input type="checkbox"/> FAILURE/MALFUNCTION		

SECTION III - MISSION INFORMATION

8. MISSION ID NUMBER	9. AIRCRAFT TYPE/ TAIL NUMBER	10. EN-PLANE ICAO	11. DE-PLANE ICAO	12. ORIGINATING FACILITY	13. DESTINATION FACILITY	14. CCATT ONBD? <input type="checkbox"/> YES <input type="checkbox"/> NO
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SECTION IV - PERSON AFFECTED

15.a. LAST NAME	b. FIRST NAME	c. AGE	d. SEX	e. STATUS	f. GRADE
16. CITE NUMBER	17. UNIT OF ASSIGNMENT				
18. PATIENT CLASS	19. MOVEMENT PRECEDENCE (<i>X one</i>) <input type="checkbox"/> U <input type="checkbox"/> P <input type="checkbox"/> R				

20. CONTACT INFORMATION OF PERSON AFFECTED

a. ADDRESS (<i>Include ZIP code</i>)	b. TELEPHONE NUMBER (<i>Include area code</i>)
	c. E-MAIL ADDRESS

21. DIAGNOSIS

22. MEDICAL EVALUATION TREATMENT RECEIVED (<i>X and complete as applicable</i>)	YES	NO	N/A
a. DID THE PERSON RECEIVE A MEDICAL EVALUATION AND/OR TREATMENT FOLLOWING THE EVENT?			
b. WAS THE PERSON EVALUATED AND/OR TREATED BY A PHYSICIAN ON THE AIRCRAFT OR FLIGHT LINE?			
IF YES, CREDENTIALLED HEALTHCARE PROVIDER NAME:			
c. WAS THE PERSON EVALUATED AND/OR TREATED AT THE MTF?			
IF YES, MTF NAME AND LOCATION:			
d. IF EVALUATION OR TREATMENT WAS RECOMMENDED, WAS IT REFUSED?			

SECTION V - ASSESSMENT

23. EVENT CLASSIFICATION (*X as applicable*)

a. EVENT RESULTING IN THE DEATH, NEAR DEATH OR MAJOR PERMANENT LOSS OF FUNCTION.
b. EVENT RESULTING IN TEMPORARY PATIENT HARM AND INITIAL OR PROLONGED HOSPITALIZATION.
c. EVENT RESULTING IN TEMPORARY PATIENT HARM AND EMERGENCY EVALUATION AND/OR TREATMENT.
d. EVENT DID NOT RESULT IN PATIENT HARM, BUT INCREASED MONITORING REQUIRED.
e. EVENT DID NOT RESULT IN PATIENT HARM OR NEED FOR INCREASED MONITORING.
f. EVENT DID NOT REACH PATIENT AND DID NOT RESULT IN PATIENT HARM.

24. DESCRIPTION OF EVENT (*Concise, factual, objective statement*)

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24.a. IMMEDIATE ACTIONS TAKEN

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