State of Connecticut
Department of Public Health
Facility Licensing & Investigations Section
Reportable Event Form

Facility Name:_____

Facility Address:_____

Telephone:_____ Bed Capacity: _____CCNH: _____RHNS: _____CCNH/RHNS:_____

Date of report_____ Report Number:_____ Classification: A ☐ B☐ C☐ D☐ E☐

Is this a "Follow up" to previously submitted form? Yes ☐ No ☐ (If Yes - **Attach Original Report**)

Patient Information

Name: _____ Age: _____

Date of Admission:_____ Room #_____

Current Diagnoses:_____

Date of Event:_____ Time of Event: _____AM ☐ PM ☐ Location of event: _____

Nature and Description of Event:_____

_____

_____

Injury, Distress and/or Discomfort (if any):_____

_____

Full Name of Witness(es): _____

Functional Status	***Before Event***	***After Event***
Mental Status (include cognition, mood and behavior)		
Physical Status (include ADL function and assistance required as applicable, ie. mobility,eating transfer, ambulation, bathing, toileting, restraints)		

Name of Physician Notified:_____ Date/Time of Notification:_____

Physical Exam: Yes ☐ No ☐ Physician Report Findings/Orders/Treatment:_____

_____

Disposition/Comments/Actions Taken: _____

_____

Family Notification: Yes ☐ No ☐ Police Notification: Yes ☐ No ☐ Investigation Initiated: Yes ☐ No ☐

For Class A, B or C, Date and Time DPH was notified by Telephone:_____

Signature of Person Filing Report:_____Date:_____

Signature of Administrator:_____Date:_____