MARYLAND DEPARTMENT OF THE ENVIRONMENT

1800 Washington Boulevard · Baltimore Maryland 21230

(410) 537-3193 · 1-800-633-6101 · Fax (410) 537-3198 · mdexray.submission@maryland.gov

DIAGNOSTIC MEDICAL EVENT OCCURRENCE LOG

Facility Registration Number: _____ ID # _____*

***We ask that the following naming system be used when submitting your log.**

1. **Registration Number**
2. **Dash (-)**
3. **Month of Event**
4. **Dash (-)**
5. **Year of Event**
6. **Dash (-)**
7. **Event Occurrence Number**

ID Number (#): (An example would look like: 23-4568-4-2016-001)

Facility Name: _____

Address: _____

Prescribing Physician: _____

Reported By: _____ **Title:** _____

Email: _____ **Phone Number:** _____

Event discovered by:

- ☐ Prescribing Physician
- ☐ Radiologist
- ☐ Medical Physicist
- ☐ Radiologic Technologist
- ☐ Nurse, Nurse Practitioner or Physicians Assistant
- ☐ Patient
- ☐ Other _____

Date of Occurrence: _____ **Date of Discovery:** _____ **Date Reported:** _____

Event reported within 24 hour period (next working business day):

- ☐ Yes
- ☐ No

Time of Occurrence:

_____ A.M. _____ P.M.

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Years of Involved Staff:

☐ < 5 years ☐ 5-10 years ☐ > 10 years

Facility Type: ☐ Dental ☐ Hospital ☐ Veterinarian ☐ Medical (Urgent Care, Podiatrist, Chiropractic, etc.)

Department (If applicable):

☐ Emergency Room
☐ Imaging
☐ Emergency (Shock Trauma)
☐ Outpatient

Modality Used: ☐ General X-ray ☐ CT ☐ Fluoroscopy ☐ Other _____

Modality Intended: ☐ General X-ray ☐ CT ☐ Fluoroscopy ☐ Other _____

Machine Model/Manufacturer/MDE Machine Number: _____

Type of Medical Event: ☐ Wrong patient ☐ Wrong site ☐ Wrong modality

Intended Exam/Site: _____

Actual X-ray Exam Site: _____

More than One Patient Incorrectly X-rayed: ☐ Yes ☐ No If Yes, how many: _____

Patient Notified (24 hours): ☐ Yes ☐ No Reason _____

Referring Physician Notified (24 hours): ☐ Yes ☐ No (Reason): _____

Number of Views or Fluoroscopic Time: _____

Total Effective Dose: _____mSv/mGy **Dose Report Completed by:** _____

Adverse Effect(s) on Patient(s): ☐ No ☐ Yes (Describe): _____

Brief Description:

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Check All that Apply:

Contributing Factor(s):

- ☐ Failure to properly identify patient
- ☐ Failure to verify requisition
- ☐ Distraction
- ☐ Change of routine
- ☐ Patient incoherent or unconscious
- ☐ Understaffed
- ☐ Lack of training
- ☐ New employee
- ☐ New equipment
- ☐ Heavy workload
- ☐ Other (Explain): _____

_____

_____

Determined Root Cause(s):

- ☐ Failure to follow procedures
- ☐ Human error
- ☐ Equipment/Electrical Malfunction
- ☐ Gross negligence
- ☐ Other (Explain): _____

_____

_____

Total Diagnostic Procedures Per Year:

_____

_____

Annual Procedures for Modality Involved:

_____

_____

Continue on following page.

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Corrective Actions:

☐ Policy changes
Effective date of change: _____
Description: _____
_____

☐ Procedural changes
Effective date of change: _____
Description: _____
_____

☐ Equipment changes/upgrade
Effective date of change: _____
Description: _____
_____

☐ Software changes/upgrade
Effective date of change: _____
Description: _____
_____

☐ Other (Expain): _____
_____

Facility Representative Signature: _____ Date: _____

IMPORTANT: Retain this record for 3 years from the report date.