



**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
AMBULATORY SURGICAL CENTER
INCIDENT REPORT FORM**

Name of Facility: _____

Address: _____

Contact person: _____

Telephone: _____ Email: _____

Facility License #: _____ CCN #: _____

Reporting Information

1. Date report completed: _____

2. Date of incident: _____

3. Type of incident:

Death of a patient while under the care of the ASC

The transfer of a patient to a hospital

Patient development of complications within 24 hours of discharge from the ASC resulting in admission to a hospital

A patient stay exceeding 23 hours

Occurrence of fire in the ASC

Theft of drugs and/or diversion of controlled drugs

4. Summary of reportable incident; what happened and how it was handled: *(do not send medical records with this form – you will be contacted if additional information is needed)*

Return this form by mail OR fax within 10 business days of the incident to:

Texas Department of State Health Services
Facility Licensing Group – Mail Code 2835
PO Box 149347

Austin, Texas 78714-9347
Fax: (512) 834-4514