

Agency for Health Care Administration
Hospital and Outpatient Services Unit
2727 Mahan Drive, Mail Stop 31
Tallahassee, FL 32308
Phone #: (850) 487-2717 Fax #: (850) 922-4351

Adverse Reaction Report Form *

*Adverse reactions are to be reported to AHCA immediately. Part I of the form is to be submitted to AHCA within 2 days of the event. Part II is to be submitted when the final determination of cause has been determined. When the adverse reaction is due to donor organs or tissues, recall procedures shall be instituted in accordance with Ch. 59A-1.005(15), F.A.C., and look back procedures in accordance with Ch. 59A-1.005(16), F.A.C.

Part II

Date: _____ Report ID #: _____

I. Determination of Cause:

Cause:

- Probably due to donor organ or tissue
 Probably not due to donor organ or tissue

Basis for determination of cause:

II. Action Plan Completion:

Describe all actions completed in accordance with the action plan submitted in Part I:

III. Person Filing Report:

Name (print): _____ Signature: _____

Date: _____