

STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF OPERATIONS SUPPORT  
HEALTH FACILITIES ADMINISTRATION  
129 PLEASANT STREET, CONCORD, NH 03301

Enclosure #1

**Adverse Event  
Initial Report**

Email- [adverseevents@dhhs.nh.gov](mailto:adverseevents@dhhs.nh.gov)

Initial Report	
1.	Hospital or Ambulatory Surgical Center Name:
2.	Date Initial Report sent to the Department:
3.	Year Event occurred:
4.	Date Event Discovered:
5.	Patient Gender:
6.	Check here <input type="checkbox"/> if patient is older than 89 years, or, if under 90 years of age then Patient Age is:
7.	Patient Admitting Diagnosis:
8.	Location (i.e. unit/floor/wing/department, OR #, satellite address etc.) of where event took place:
9.	Adverse Event Category: (i.e. RSA 151:38 (a)-(f)):
10.	Adverse Event Brief Description:
11.	Hospital or Ambulatory Surgical Center Contact Person Name & Title:
12.	Hospital or Ambulatory Surgical Center Contact Email & Phone #: