Prescribed by: DoDI 6025.13

PATIENT MOVEMENT EVENT/NEAR MISS REPORT

(Information placed on this form is confidential and privileged in accordance with 10 U.S.C. 1102. Do not file or refer to this form in a patient record.)

PRIVACY ADVISORY: When completed, this form contains personally identifiable information and personal health information and should be protected in accordance with DoD 5400.11-R (the DoD Privacy Program).

Prepare this form to document events that resulted in or had the potential to result in harm to anyone in the PM system.
NOTE: If completed by ASF or other MTF staff follow local MDG incident reporting policy in addition to completing this form.

SECTION I - PERSON COMPLETING FORM

1.a. LAST NAME	b. FIRST NAME	c. MIDDLE INITIAL

d. GRADE	e. UNIT OF ASSIGNMENT

f. TELEPHONE NUMBER *(Include area code)*	g. EMAIL ADDRESS	h. SIGNATURE

i. WITNESSES TO EVENT

(1) NAME/GRADE	(2) UNIT OF ASSIGNMENT OR ADDRESS	(3) TELEPHONE	(4) EMAIL ADDRESS

j. PMQ-R GENERATED LOG NUMBER *(For PM Safety Manager)*:

SECTION II - GENERAL INFORMATION

2. DATE *(YYYYMMDD)*/ TIME *(Z)* OF EVENT	3. LOCATION OF EVENT *(Be specific)*		
	a. MTF:	d. EN ROUTE HOLDING AREA:	g. AIRCRAFT *(In-flight)*:
	b. ASF/ASTS:	e. GROUND TRANSPORT:	h. OTHER:
	c. OTHER RON:	f. AIRCRAFT *(Ground)*:	

4.a. MAJCOM RESPONSIBLE FOR MISSION	b. SUBMITTING UNIT

5. DID THIS EVENT RESULT IN DEATH, NEAR DEATH OR HOSPITALIZATION? *(X appropriate block)* ☐ YES ☐ NO
IF YES, CONTACT THE PMRC AS SOON AS POSSIBLE TO REPORT EVENT.

6. PERSON AFFECTED OR POTENTIALLY AFFECTED BY THIS EVENT *(X appropriate block)*

☐ PATIENT ☐ PAX ☐ CREW ☐ FACILITY STAFF ☐ ATTENDANT ☐ CCATT MEMBER

7. EVENT CATEGORY *(X as applicable)*

a. MEDICATION ☐ MEDICATION ERROR ☐ NARCOTIC NOT ACCOUNTED FOR ☐ SELF MEDICATION ISSUE

b. STATUS CHANGE

☐ AE PROTOCOL USED ☐ DEATH IN-FLIGHT ☐ SEIZURES
☐ ALLERGIC REACTION ☐ DEATH WITHIN 24 HOURS ☐ SHORTNESS OF BREATH
☐ BIRTH ☐ DESATURATION ☐ SUICIDE
☐ CARDIAC/RESPIRATORY ARREST ☐ MEDICATION RESPONSE ☐ TRANSIENT/MILD STATUS CHANGE
☐ CHEST PAIN

c. PATIENT PREP

☐ ATTENDANT ISSUES ☐ MEDICATION ☐ SUPPLIES
☐ DOCUMENTATION OF CARE ☐ ORDERS ☐ TREATMENT NOT DONE PRIOR TO FLIGHT
☐ EQUIPMENT ☐ PAPERWORK

d. OTHER

☐ AIRCRAFT AMPERAGE ☐ COMMUNICATION ☐ NO MEALS SUPPLIED
☐ AIRCRAFT EMERGENCY ☐ FLIGHT CREW EQUIPMENT/MSN DUTY ☐ PMRC
☐ AIRCRAFT MAINTENANCE DELAY ☐ INDIVIDUAL BODY ARMOR ☐ TRANSPORTATION ISSUES
☐ BAGGAGE ISSUES ☐ MEDICAL DELAY

e. PATIENT HANDOFF ☐ INADEQUATE PATIENT HANDOFF ☐ NO PATIENT HANDOFF

f. INFECTION CONTROL ☐ BLOOD OR OTHER BODY FLUID EXPOSURE ☐ TRANSPORTATION OF INFECTIOUS PATIENT

g. ASF/RON SPECIFIC ☐ ASF/RON TRANSPORTATION ISSUES

h. ANTI-HIJACK ☐ COMPLETED INCORRECTLY ☐ NOT COMPLETED

i. INJURY ☐ ACTUAL ☐ POTENTIAL

j. EQUIPMENT

TYPE OF EQUIPMENT	MODEL NUMBER/SERIAL NUMBER *(If applicable)*

☐ NOT APPROVED FOR FLIGHT ☐ WAIVER REQUIRED ☐ FAILURE/MALFUNCTION

SECTION III - MISSION INFORMATION

8. MISSION ID NUMBER	9. AIRCRAFT TYPE/ TAIL NUMBER	10. EN-PLANE ICAO	11. DE-PLANE ICAO	12. ORIGINATING FACILITY	13. DESTINATION FACILITY	14. CCATT ONBD?
						☐ YES ☐ NO

SECTION IV - PERSON AFFECTED

15.a. LAST NAME	b. FIRST NAME	c. AGE	d. SEX	e. STATUS	f. GRADE
			☐ M ☐ F		

16. CITE NUMBER	17. UNIT OF ASSIGNMENT

18. PATIENT CLASS	19. MOVEMENT PRECEDENCE *(X one)* ☐ U ☐ P ☐ R

20. CONTACT INFORMATION OF PERSON AFFECTED

a. ADDRESS *(Include ZIP code)*	b. TELEPHONE NUMBER *(Include area code)*
	c. E-MAIL ADDRESS

21. DIAGNOSIS

22. MEDICAL EVALUATION TREATMENT RECEIVED *(X and complete as applicable)*	YES	NO	N/A
a. DID THE PERSON RECEIVE A MEDICAL EVALUATION AND/OR TREATMENT FOLLOWING THE EVENT?	☐	☐	☐
b. WAS THE PERSON EVALUATED AND/OR TREATED BY A PHYSICIAN ON THE AIRCRAFT OR FLIGHT LINE?	☐	☐	
IF YES, CREDENTIALED HEALTHCARE PROVIDER NAME:			
c. WAS THE PERSON EVALUATED AND/OR TREATED AT THE MTF?	☐	☐	
IF YES, MTF NAME AND LOCATION:			
d. IF EVALUATION OR TREATMENT WAS RECOMMENDED, WAS IT REFUSED?	☐	☐	

SECTION V - ASSESSMENT

23. EVENT CLASSIFICATION *(X as applicable)*

- ☐ a. EVENT RESULTING IN THE DEATH, NEAR DEATH OR MAJOR PERMANENT LOSS OF FUNCTION.
- ☐ b. EVENT RESULTING IN TEMPORARY PATIENT HARM AND INITIAL OR PROLONGED HOSPITALIZATION.
- ☐ c. EVENT RESULTING IN TEMPORARY PATIENT HARM AND EMERGENCY EVALUATION AND/OR TREATMENT.
- ☐ d. EVENT DID NOT RESULT IN PATIENT HARM, BUT INCREASED MONITORING REQUIRED.
- ☐ e. EVENT DID NOT RESULT IN PATIENT HARM OR NEED FOR INCREASED MONITORING.
- ☐ f. EVENT DID NOT REACH PATIENT AND DID NOT RESULT IN PATIENT HARM.

24. DESCRIPTION OF EVENT *(Concise, factual, objective statement)*

24.a. IMMEDIATE ACTIONS TAKEN