

Malpractice Insurers Medical Error Prevention Study

1. ADMINISTRATIVE SCREENING DATA FORM

Subject Number (FOR OFFICE USE ONLY)

Date of Review

Insurance Company Code Number

Claim Number

Reviewer ID #

1. Was the incident reported to the insurer prior to the claim being asserted?
 - Yes
 - No
 - ND

2. Please categorize each **clinician** defendant named.
(See specialty code list)

Defendant(s)	Specialty Code	Year Completed Specialty Training
Clinician Defendant #1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND
Clinician Defendant #2	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND
Clinician Defendant #3	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND
Clinician Defendant #4	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND
Clinician Defendant #5	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND
Clinician Defendant #6	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> ND

3. Please categorize each **facility** defendant named.

Defendant(s)	Facility type
Facility #1	<input type="radio"/> Hospital – inpatient <input type="radio"/> Outpatient / clinic <input type="radio"/> Ambulatory surgery <input type="radio"/> Physician office <input type="radio"/> ND
Facility #2	<input type="radio"/> Hospital – inpatient <input type="radio"/> Outpatient / clinic <input type="radio"/> Ambulatory surgery <input type="radio"/> Physician office <input type="radio"/> ND
Facility #3	<input type="radio"/> Hospital – inpatient <input type="radio"/> Outpatient / clinic <input type="radio"/> Ambulatory surgery <input type="radio"/> Physician office <input type="radio"/> ND

No facility defendant evident

4. Date claim initiated:

□□/□□/□□□□

ND

5. Date of occurrence (loss date) of treatment or management that allegedly led to injury:

□□/□□/□□□□

ND

6. **TOTAL expenses:**
(i.e. sum of expenses accrued on behalf of all defendant(s) insured by your company—excluding payment/indemnity amounts)

\$ _____

ND

7. **TOTAL indemnity paid:**
(i.e. sum of indemnity payments made on behalf of defendant(s) insured by your company)

\$ _____

ND

8. Details of indemnity payment(s)

Disposition code:

1 = Dropped/Denied/Dismissed

2 = Settled

3 = Defense Verdict

4 = Plaintiff Verdict

Defendant #	Date of Closure	Disposition Code	Indemnity Allocation (i.e. % of total from Q8)
Defendant #1	□□/□□/□□□□	□	_____ %
Defendant #2	□□/□□/□□□□	□	_____ %
Defendant #3	□□/□□/□□□□	□	_____ %
Defendant #4	□□/□□/□□□□	□	_____ %
Defendant #5	□□/□□/□□□□	□	_____ %
Defendant #6	□□/□□/□□□□	□	_____ %
<input type="radio"/> ND			

9. Patient's date of birth:

/ /

ND

10. Patient's zip code (home/residence):

ND

11. Patient's insurance status:

Private insurance

Medicare

Medicaid

Uninsured

Other (specify): _____

ND

12. Did the initial event that gave rise to the claim occur, in part or whole, during an **inpatient** stay?

Yes

No

13. Specify the **pre-event** ICD9 Code (if multiple codes, choose primary one)

ND

14. Was the incident related to a **procedure** or **procedures**:

Yes

No (**Skip to 16**)

15. If yes, please specify the CPT code for the procedure(s):

CPT Code (#1): ND

CPT Code (#2): ND

CPT Code (#3): ND

16. What was the **insurer's** categorization of the degree of **disability** attributable to the **patient's** alleged injury or poor outcome?

- No injury
- Emotional disability only: (e.g. fright; no physical damage)
- Temporary insignificant: (e.g. lacerations, contusions, minor scars, rash; no delay in recovery)
- Temporary minor: (e.g. infections, missed fracture, fall in hospital; recovery delayed)
- Temporary major: (e.g. burns, surgical material left, drug side effect, brain damage; recovery delayed)
- Permanent minor: (e.g. loss of fingers, loss or damage to organs, includes non-disabling injuries)
- Permanent significant: (e.g. deafness, loss of limb, loss of eye, loss of one kidney or lung)
- Permanent major: (e.g. paraplegia, blindness, loss of two limbs, brain damage)
- Permanent grave: (e.g. quadriplegia, severe brain damage, lifelong care, fatal prognosis)
- Death
- Injury, but no categorization of severity evident

SPECIALTY CODES*MMM. Unknown***Generalist Physicians***

101. Generalist/Primary Care (includes: Internal Medicine, Hospitalist, General Practice, Family Practice, General Primary Care)

Specialist Physicians*

201. Cardiology	212. Geriatrics
202. Hematology/Oncology	213. Genetics
203. Nephrology	214. Occupational Medicine
204. Neurology	215. Physical Medicine & Rehab/Psychiatry
205. Rheumatology/Immunology	216. Obstetrics/Gynecology
206. Gastroenterology	217. Anesthesiology
207. Dermatology	218. Pediatrics/Neonatology
208. Endocrinology	219. Radiology/Imaging
209. Pulmonary Disease	220. Pathology
210. Infectious Disease	221. Emergency Medicine
211. Intensive Care	222. Psychiatry

Surgeons*

301. General Surgery	306. Vascular Surgery
302. Orthopedic Surgery	307. Neurosurgery
303. Cardio/Thoracic Surgery	308. Plastic Surgery
304. Ophthalmology	309. Urology
305. ENT	

***For Fellows list relevant 3-digit code and place “F” in 4th box, for Residents list relevant 3-digit code and place “R” in 4th box, and for Interns list relevant 3-digit code and place “I” in 4th box.**

Nursing Professionals

401. Registered Nurse
 402. Licensed Practical Nurse
 403. Nurse Practitioner/Clinical Nurse Specialist
 404. Nurse Midwife
 405. Nurse Anesthetist

Other Professional Services

501. Dentistry/Oral Surgery	510. Naturopathy (by MD/DO)
502. Substance Abuse Treatment	511. Naturopathy (by non-physician)
503. Physical Therapy	512. Massage Therapy (by MD/DO)
504. Occupational Therapy	513. Massage Therapy (by non-physician)
505. Speech Therapy	514. Homeopathy (by MD/DO)
506. Acupuncture (by MD/DO)	515. Homeopathy (by non-physician)
507. Acupuncture (by non-physician)	516. Physician Assistant
508. Chiropractic (by MD/DO)	517. Pharmacist
509. Chiropractic (by non-physician)	518. Patient Care Assistants
	519. Other health professional

Trainee

601. Medical student
 602. Nursing Student (graduate or undergraduate)
 603. Student of other health profession