MEDICATION ERROR REPORT- Attach this to Unusual Event Form

Client Name: _____ Date of Birth: _____

Date of Med. Error (mm/dd/yy): _____ Time: _____

Location of Occurrence: _____ Name of RN Notified: _____

☐ 911 Called ☐ Poison Control Called ☐ Transported to ED

Individual Completing This Report: _____ Title: _____

Signature: _____

Name of Staff Member Involved: _____ Title: _____

Name of Medication(s)	Dose	Times Given

☐ Medication Given to the Wrong Person ☐ Wrong Dose of Medication Given ☐ Wrong Medication Given ☐ Medication Not Given OTHER:	☐ Medication given by Wrong Route ☐ Medication Not Given at the Right Time ☐ Family Error ☐ Client Refused Medication

Client Required Medical Intervention:

_____

_____

_____

_____

This Section to be Completed by Supervisory Personnel

Follow-up/Corrective Action taken or Plans:

_____

_____

_____

Name: _____ Title: _____Signature: _____

Contact Phone Number: _____

Contact Email: _____