

# Partners in Recovery

## Medication Incident Reporting Form

Consumer Name: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Consumer ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Location/Address of facility where incident occurred: \_\_\_\_\_

### Where did the incident occur:

Consumer's home

Hospital

Outpatient clinic

Pharmacy

Residential placement

Other:

### Nature of medication incident?

Medical dose omission

Extra dose of medication given

Medication given after documented allergy

Medical given without an order

Medical given at wrong time

Medication given to wrong consumer

Adverse Medication Reaction

Wrong medication given

Wrong dose given

### Who was notified?

Supervisor  Consumer  Family  MD/NP/PA  RN  Pharmacist  Case Manager

Was the incident documented in the medical record? Yes  No  Unknown

Were medical services required? Yes  No

If "Yes," document the date and time OBHL was notified: \_\_\_\_\_

Brief description of incident: \_\_\_\_\_

\_\_\_\_\_  
Staff Member Name

\_\_\_\_\_  
Staff Member Signature

\_\_\_\_\_  
Date: