Green Mountain Support Services
Medication Incident / Error Report

Date: _____Client: _____DOB: _____Allergies: _____

Service Coordinator: _____Date/Time notified: _____/_____

Medication Incident / Error Report

Was medication given? Yes___ No ___ Adverse effect on client: Yes___ No ___

Medication, dose, route ordered:_____ Time ordered:_____

Medication, dose, route administered: _____ Time administered: _____

Incident Type (Please check off all that apply):		
__Client Refused **__Client Vomited** **__Communication Challenge** **__Order Issue or Error** **__Pharmacy Issue or Error** **__Mislabeled** **__Other (Please specify):** **_____**	**__No Medical Provider's Order** **__Discontinued Medication** **__Omitted or Forgotten** **__Documentation** **__Computation** **__Other (Please specify):** **_____**	**__Wrong Client** **__Wrong Medication** **__Wrong Dose / Overdose** **__Wrong Route** **__Wrong Time** **__Wrong Indication(Reason)** **__*Client Harm Resulting**

Description of medication incident (Includes additional medications involved and any adverse effects on client): _____

Please continue documenting on back of sheet if more room is needed.
*Notify medical provider(s) / nursing immediately.

Please See Reverse

Revised: July 2019

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Description continued from front (if needed):

Description of medication incident follow up by Nursing and/or Service Coordinator:

Individual Reporting Incident	**(Date)**	**Service Coordinator**	**(Date)**
Supervisor / Leadership	**(Date)**	**Agency Nurse**	**(Date)**

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