MEDICATION ERROR FORM

(Level 1 Incident Reporting)

Resident Name____Birthdate______________________________

Medicaid Number____MRN_________________________________

Name of Medication in error

Explain how the error occurred

Have any negative symptoms been observed?

Did you contact the guardian?

Did you contact the facility QP?

Did you contact the ordering physician's office?

Who in the office did you speak too? Time and Date?

Questions for the Physician

Are there any symptoms or concerns that could present themselves that should be monitored for safety purposes?

Could we expect any adverse reactions due to this error?

Does the resident need to be seen in your office due to the error?

Any additional comments or guidance from the physician?

Employee Signature and Date