Champlain Community Services

MEDI CATION ERROR REPORT

Consumer Name:_____ Date:_____ Time:_____

Person Reporting:_____

Location of Incident:_____

Others Present:_____

Cause of Medication Error:

_____ WRONG MED

_____ WRONG TIME

_____ WRONG DOSE

_____ WRONG ROUTE

_____ WRONG PERSON

_____ MISSED DOSE

Description of Error:_____

_____

_____

_____

GUIDELINES

1. **YOU *MUST* CALL THE *PRESCRIBING* PHYSICIAN FOR ALL MISSED OR WRONGLY GIVEN MEDS**
2. **THE CONSUMER'S SERVICE COORDINATOR *MUST* ALSO BE NOTIFIED**
3. **IF NOT AN EMERGENCY, YOU DO NOT NEED TO USE THE MD'S AFTER-HOURS EMERGENCY NUMBER**
4. **YOU DO NOT HAVE TO CALL THE DOCTOR FOR A MED COUNT DEVIATION ALONE**
5. **RECORD ANY INSTRUCTION FROM THE PHYSICIAN ON THIS FORM**
6. ***REMINDER:* MEDS CAN ONLY BE GIVEN AS EARLY AS 1 HR BEFORE, OR 1 HR AFTER THE ASSIGNED TIMES**

Prescribing Physician Notified:_____ Time Notified:_____

Service Coordinator Notified: _____ Time Notified:_____

Service Coordinatorôs Signature:_____ Date:_____

RN Follow-Up Needed? Y_____N_____. Date Notified:_____ Comments:_____

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