Medication Incident Report

Patient Name ______________________________ Room ____________________
Last First

Type of Incident:

____	Adverse drug reaction	____	Given without Doctor's Order
____	Omission of a dose	____	Given past stop order date
____	Incorrect dose	____	Drug not available (lost, etc.)
____	Incorrect drug	____	Charting Omission
____	Incorrect patient	____	Charted incorrectly
____	Incorrect frequency	____	Other: ____________

Drug Involved (Name, Form and Strength): ______________________________
____

Description of Incident, Date, Time and Location: ______________________
____
____

Immediate Action Taken: Yes ______ No ______ If No, explain: ____
____
____

Action Taken To Prevent Re-Occurrence: ______________________________
____
____

Was Patient Seen By Physician: Yes ____ No _____

Physician's Name ____

Report Submitted By: ______________________________ Date __________
Signature Title

Physician's Statement: ____
____
____

Physician's Signature: ____

The incident has discussed with me, and I have been taught the proper procedure.

Signature of Nurse Involved ____________________ Date __________

Reviewed By: Pharmacist ____________________ Date __________
Director of Nursing ____________________ Date __________
Administrator ____________________ Date __________
Medical Director ____________________ Date __________

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