SAVE PRINT

Medication Error Report

Client Name:_____ Date:
Agency: Center for social change

TYPE OF MEDICATION ERROR: (circle the appropriate number)

1. Incorrect client
2. Incorrect dose
3. Incorrect time
4. Missed medication
5. Failure to document administration of medication
6. Incorrect medication
7. Other Error

Date of error:_____

Name of Staff(s) involved in error:_____

List medications involved in the error: _____

_____

Describe medication error: _____

_____

_____

_____

_____

_____

_____

_____

_____

THE FOLLOWING INDIVIDUALS WERE NOTIFIED:

Nurse's Name:_____ Date:_____ Time:_____

Supervisor's Name:_____ Date:_____ Time:_____

Individual writing report signature:_____Date:_____

Supervisors (Director) signature: _____ Date:_____