# MEDICATION OCCURRENCE REPORT

**Name of Individual:** _____ **Region:** _____ **DOB:**_____

**Date(s) of Occurrence:**_____ **Time of Occurrence:**_____ ☐**AM** ☐**PM**

**Certification Address:** _____ **Name of Provider Agency:** _____

**Type of Service:** He-M 1001 ☐ 507 ☐ 518 ☐ 521 ☐ 524 ☐ 525 ☐ Other_____

**MEDICATION ERROR**
- ☐ Wrong Med
- ☐ Wrong Time
- ☐ Wrong Dose
- ☐ Wrong Person
- ☐ Wrong Route
- ☐ Omission

**DOCUMENTATION ERROR**
- ☐ Med log error
- ☐ Controlled Drug Count not done
- ☐ Controlled Drug Count incorrect
- ☐ Other_____

**OTHER CONCERNS**
- ☐ Missing med
- ☐ Unauthorized person administered med
- ☐ Other_____

**REFUSAL-**
Use regular incident report form & notify nurse

| Name of Medication(s) Involved | Dose: | Frequency: | Route: | Purpose of Medication: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Describe what happened** (including any impact to individual):

_____
_____
_____
_____
_____

**Name, Date & Time Nurse Trainer was notified:** _____**By Whom:** _____

**Instructions received from Nurse Trainer:** _____
_____
_____

**Action(s) Recommended by Medical Professional & Taken by Authorized Provider** (person authorized to administer meds)_____

| **Who was notified (Include name, date/time and method of contact) (Guardian notification, if applicable):** | | | | |
|---|---|---|---|---|
| **Name** | **Relationship to individual** | **Date** | **Time** | **Method of contact** |
| | Service Coordinator | | ☐am ☐pm | |
| | Program Supervisor | | ☐am ☐pm | |
| | Guardian(s) | | ☐am ☐pm | |
| | Prescribing Practitioner | | ☐am ☐pm | |

**Report written by:** _____**Date:** _____



Revised 6/7/17

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**Name of Individual:** _____ **Date(s) of Occurrence:** _____

**TO BE COMPLETED BY THE PERSON RESPONSIBLE FOR THE OCCURRENCE:**

**Person responsible for Medication Occurrence:**_____

**Describe How and Why the Occurrence Happened:**

_____
_____
_____

**Suggestions to prevent future occurrence:** _____
_____
_____
_____

**Signature of Person Responsible:** _____**Date Completed**: _____

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**NURSE TRAINER REVIEW: to be completed by Nurse Trainer**

**Type of Occurrence:** _____

**Cause of Occurrence**: _____
_____
_____
_____

**Immediate Actions taken in regard to this situation/ Authorized Provider (e.g. corrective action):**

_____
_____
_____
_____
_____

**Systemic Recommendations to prevent future occurrence(s):**

_____
_____
_____
_____

**Signature of Nurse Trainer:** _____**Date completed:** _____

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**MANAGEMENT REVIEW: to be completed by Program Director/ Designee**

**Review of Authorized Provider and Nurse Trainer Response & Include any Additional Follow-up:**

_____
_____
_____
_____

**Signature of Program Director/ Designee:** _____**Date Completed:** _____



Revised 6/7/17