**MEDICATION OCCURRENCES REPORT**

Read all directions below carefully before filling out entire report.

Directions: Call Nursing and Program Director/ Residential Coordinator.

Complete investigation and medication occurrence form and send to Nursing within 48 hours.

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| **Client Name** |  | | | | | **Today’s Date** | | | | | |  | | | **Time** | |  | |
| **Program Site** |  | | | | | **Duration of Occurrence** | | | | | | | |  | | | | |
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| Complete list all the following information for all medication (s) involved: | | | | | | | | | | | | | | | | | | |
| **Medication (s)** | | **Dose** | **Frequency** | | **Route** | | | | | | **Prescribing Clinician** | | | | | | | |
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| **Short Summary of Error: (Documentation Error)** | | | | | | | | | | | | | | | | | | |
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| Communication: | | | | | | | | | | | | | | | | | | |
| **Nurse Trainer** |  | | | **Yes** | | | | **No** | | **Date** | | |  | | | **Time** | |  |
| Informed in office of ordering clinic: | | | | **Yes** | | | | **No** | | **Date** | | |  | | | **Time** | |  |
| **Doctor Name** |  | | | | | | | | |  | | | | | | | | | |
| **Instructions/ Recommendations from Nurse Trainer:** | | | | | | | | | | | | | | | | | | |
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| **Besides being more careful/attentive how could this error have been prevented?** | | | | | | | | | | | | | | | | | | |
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| Signature of person involved in occurrence: | | | |  | | | | | | | | | | | | | | |
| Signature of person reporting occurrence: | | | |  | | | | | | | | | | | | | | |
| Signature of Supervisor/Nurse Trainer: | | | |  | | | | | | | | | | | | | | |
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| Medical Care/ Intervention Necessary? | | | | Yes | | |  | | No |  | |  | | | | | | | |
| **Note: If client requires Medical Care or Intervention a significant incident report is to be completed.** | | | | | | | | | | | | | | | | | | |
| **Names of other persons notified:** | | | | | | | | | | | | | | | | | | |
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