**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: |  |
|  |
| 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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