

MEDICATION INCIDENT REPORT

Person Served Name: _____

Date/Time of Error: _____

Name of Person Administering Medication: _____

Name of Medication: _____ Dosage: _____ Route: _____

Time (s) to be given: _____

Circle all that apply to this medication error:

Wrong Person

Wrong Time

Wrong Dose

Wrong Route

Wrong Medication

Wrong Documentation

Wrong Count

Describe the error (Should be completed by the person making the error. If wrong medication given, include the name and dosage of what was given.):

Action Taken/Intervention: _____

Persons notified at time of error:

Supervisor: _____ Date/time of notification: _____

Name of Person Completing Incident Report: _____

Signature & Date (person completing incident report): _____

To be completed by Supervisor

Parent or Guardian Notified: _____ Date/time notified: _____

DDS Report Completed and Sent: _____ Yes _____ No Date: _____
Name

Supervisor Name & Signature: _____