MEDICATION INCIDENT AND DISCREPANCY REPORT FORM Incident Report #:

MEDICATION INCIDENT AND DISCREPANCY REPORT

1. Use for all medication incidents. Medication discrepancies can be reported at pharmacist's discretion.
2. The pharmacist discovering the error initiates the report
3. Notify physician and pharmacy manager of all **MEDICATION INCIDENTS** that could affect the health or safety of a patient

PATIENT INFORMATION

Name:_____
Address:_____
Phone:_____
Sex: _____ DOB:_____
Rx #:_____
PHIN_____

Error Date: _____
Hour Date Month Year

Pharmacist initiating report: _____

Discovery Date: _____
Hour Date Month Year

Drug ordered:
(State: drug/dose/form/route/directions for use)

- ☐ **Medication Incident:** an erroneous medication commission or omission that has been subjected upon a patient**.**
- ☐ **Medication Discrepancy:** an erroneous medication commission or omission that has not been released for the patient.

TYPE OF INCIDENT– Patient received drug:

☐ Incorrect Dose	☐ Incorrect Dosage Form	☐ Incorrect Drug
☐ Incorrect Generic Selection	☐ Incorrect Patient	☐ Incorrect Strength
☐ Outdated Product	☐ Allergic Drug Reaction	☐ Incorrect Label/Directions
☐ Drug Unavailable/Omission	☐ Drug-drug Interaction	☐ Other _____

_____
_____
_____

TYPE OF INCIDENT OR DISCREPANCY – Patient did not receive drug:

- ☐ Prescribing (specify) _____
- ☐ Dispensing (specify) _____
- ☐ Documentation (specify) _____
- ☐ Other (specify) _____

INCIDENT/DISCREPANCY DESCRIPTION

State facts as known at time of discovery. Additional details about the error by the pharmacist involved may be attached to this document.

_____
_____
_____
_____
_____
_____

DATE: _____ _____
Hour Date Month Year Signature of Pharmacist:

CONTRIBUTING FACTORS
(To be completed by pharmacist responsible)

- ☐ Improper patient identification
- ☐ Incorrect transcription
- ☐ Lack of patient counselling
- ☐ Misread/misinterpreted drug order (include verbal orders)
- ☐ Drug unavailable
- ☐ Other

DATE: _____ _____
Hour Date Month Year Signature

NOTIFICATION – Complete the following information according to Standards of Practice.

1. **Patient notified:**
   _____
   Hour Date Month Year
2. **Physician notified: ____** **Yes/No**
   _____
   Hour Date Month Year

SEVERITY

- ☐ None
- ☐ Minor
- ☐ Major
- ☐ No change in patient's condition: no medical intervention required
- ☐ Produces a temporary systemic or localized response: does not cause ongoing complications
- ☐ Requires immediate medical intervention

OUTCOME OF INVESTIGATION

FOLLOW-UP:

Problem Identification

- ☐ Lack of knowledge
- ☐ Performance problem
- ☐ Administration problem
- ☐ Other

Action

- ☐ Education provided
- ☐ Policy/procedure changed
- ☐ System changed
- ☐ Individual awareness
- ☐ Group awareness
- ☐ Other

RESOLUTION OF PROBLEM THAT RESULTED IN THE ERROR BEING MADE:

Signature: Date:
(Pharmacist filling out the form)

Signature: Date:
(Pharmacy Manager)

PHARMACY USE ONLY