SGF Monthly Medication Error Report

Month: _____

Provider: _____   Provider #:_____   Total Medication Errors for month:_____

Total Doses Prescribed (All Medications):_____

Individual: _____   SSN: _____   Error Rate: _____%

MEDICATION (Must include medication name, dosage, schedule [times per day] and route.)	Date/Time/Location of Error	Administration Site	Type of Error	Staff Member Responsible	Agency Follow-up
Med name_____ dosage_____ schedule_____ route_____ # of Doses Prescribed for Month: _____		☐ Residence ☐ Day Program ☐ Job Site ☐ Community ☐ Respite ☐ Home Visit ☐ Other	☐ Missed Dose ☐ Wrong Time ☐ Wrong Dose ☐ Wrong Medication ☐ Wrong Route ☐ Wrong Person ☐ Other		
Med name_____ dosage_____ schedule_____ route_____ # of Doses Prescribed for Month: _____		☐ Residence ☐ Day Program ☐ Job Site ☐ Community ☐ Respite ☐ Home Visit ☐ Other	☐ Missed Dose ☐ Wrong Time ☐ Wrong Dose ☐ Wrong Medication ☐ Wrong Route ☐ Wrong Person ☐ Other		
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NOTE: Medication Errors as a result of neglect/abuse must also be reported as a Class III incident.   Page _____ of _____