CENTRAL CARE
MEDICATION ERROR/DISCREPANCY REPORT

CONSUMER NAME:	BHIS#:

PLEASE CHECK (√) TYPE OF MEDICAITON ERROR/DISCREPANCY BEING REPORTED:

□ ERROR □ DISCREPANCY

□ Wrong Medication Administered	□ Wrong Dosage
□ Expired or Recalled Medication Given	□ Medication is Misprescribed
□ Medication is Given by Wrong Route of Administration	□ Medication Dosage is Missed
Other:	
Date & Time of Occurrence:	
Person(s) Responsible:	
Statement of Error or Discrepancy:	
Date & Time Prescribing Physician Notified:	
Date & Time Medical Director Notified:	
Date & Time Pharmacy Notified:	
Was personal injury involved? □ No □ Yes (if yes complete Incident Report and follow process)	
Action Taken:	

_____ _____
Signature/Title of Staff Reporting Error **Date**

_____ _____
Signature/Title of Immediate Supervisor/Team Leader **Date**

_____ _____
Signature of Register Nurse **Date**

_____ _____
Call to Primary Physician (If applicable) **Date**

Registered Nurse REVIEW:	
Director of Central Care Signature:	Date:

Revised: March 15, 2005 (Revised)