2250 S. Oneida St. Suite 100, Denver, CO 80224, T (303) 433-1975 F (303)433-1980
1465 N Union Drive Suite 102 Colorado Springs, CO 80909 F: (719) 445-0841

MEDICATION ERROR REPORT

Please Print All Information Clearly and Use One Form for Each Occurrence.

Report Date: __________

Agency/Provider (Foster Home):____

Address: ____

Date of Med. Error: _________ Time: ________ Location of Occurrence________________

Individual Completing This Report: _____________________ Title: __________________

Signature: _________________________________

Name of Youth: __________________________________ Date of Birth: ____________

Medicaid #:______________

Youth Initials (for Med. Admin. Record Error) __________________

Name of Medication: __________________ Dose: ___________ Times Given: _________

Name of Medication: __________________ Dose: ___________ Times Given: _________

Name of Medication: __________________ Dose: ___________ Times Given: _________

<u>Type of Medication Error Involved</u> *(please indicate by checking below)*

___ Medication Administration Record Not Accurately Documented

___ Medication Given to the Wrong Person

___ Newly Prescribed Order Not Initiated Properly

___ Medication Refill Not Ordered Timely

___ Other (Please Specify): ________________________________

___ Wrong Medication Given

___ Medication Not Given

___ Medication Not Given at Right Time

___ Youth Refused Medication

<u>Description of Incident and Required Medical Nursing Care:</u>

____

____

____

____

<u>Immediate Action/Intervention:</u> ____

____

Notifications:

____ Physician Date Contacted:_____________

____Caseworker Date Contacted:_____________

____Home Supervisor Date Contacted:_____________

Revised 11/7/18