



Medication Error Report

Person Served: _____

Date: _____

Location: _____

TYPE OF MEDICATION ERROR: (check the appropriate numbered box)

- | | |
|----------------------------|---|
| 1. Incorrect Person Served | 5. Failure to document administration of medication |
| 2. Incorrect dose | 6. Incorrect medication |
| 3. Incorrect time | 7. Other Error |
| 4. Missed medication | |

Date of error: _____

Name of Staff(s) involved in error: _____

List medications involved in the error:

Describe medication error:

THE FOLLOWING INDIVIDUALS WERE NOTIFIED:

Delegating Nurse's Name: _____ Date: _____ Time: _____

Supervisor's Name: _____ Date: _____ Time: _____

Signature of Individual writing report: _____ Date: _____