MEDICAL INCIDENT REPORT

This Report is Prepared for Purposes of Quality Improvement

Date of Incident:_____ Time:_____ Institution:_____

Prisoner's Name:_____ OBSCIS/MIS#:_____

☐ Medication Error

Practitioner's Order:_____

☐ Dose Omitted
☐ Wrong Dose
☐ Wrong Patient
☐ Non-Ordered Med
☐ Wrong Route
☐ Wrong Time
☐ Wrong Drug
☐ Transcription Error Only
☐ Packaging Error Only

Explain circumstances of incident:_____

_____

_____

☐ Adverse Drug Reactions

Describe reaction:_____

_____

Suspected Drug/Dose/Time:_____

_____

Other Medications/Dosages:_____

_____

☐ Other Medical Incident

Describe Incident:_____

_____

_____

_____

Interventions: ☐ None required ☐ Held dose ☐ Bed rest

Other:_____

_____

_____

Practitioner notified: ☐ Date:_____ Time:_____

Orders:_____

_____

Health Care Staff:_____ Date:_____ Time:_____

Name and Title

Copy to: IHCO, Pharmacy, Health Care Program Manager