

**CENTRAL CARE  
MEDICATION ERROR/DISCREPANCY REPORT**

CONSUMER NAME:	BHIS#:
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PLEASE CHECK (√) TYPE OF MEDICATION ERROR/DISCREPANCY BEING REPORTED:

- ERROR
  DISCREPANCY

<input type="checkbox"/> Wrong Medication Administered	<input type="checkbox"/> Wrong Dosage
<input type="checkbox"/> Expired or Recalled Medication Given	<input type="checkbox"/> Medication is Misprescribed
<input type="checkbox"/> Medication is Given by Wrong Route of Administration	<input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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: