

Incident Form

Please Type or Print

PATIENT NAME _____

DRUG NAME/STRENGTH _____

PRESCRIPTION NUMBER _____

ADDRESS _____

TELEPHONE _____

PATIENT AGE _____

DATE INCIDENT DISCOVERED _____

DATE OF DISPENSING _____

New Rx

Repeat Rx

NATURE OF INCIDENT

Incorrect Drug

Incorrect Strength

Verbal Disagreement

Incorrect Directions

Incorrect Brand

Incorrect Dosage Form

Incorrect Quantity

Other (please specify) _____

Incorrect Patient

Outdated Medication

DETAILS OF INCIDENT _____

WAS DRUG INGESTED? Yes No

If yes, was medical attention required? _____

PATIENT CONTACTED BY _____ DATE/TIME _____

PRESCRIBER CONTACTED BY _____ DATE/TIME _____

PRESCRIBER'S NAME _____ TELEPHONE _____

PRESCRIBER'S COMMENTS _____

REASON FOR INCIDENT _____

CORRECTIVE ACTION(S) TAKEN _____

