MEDICAL INCIDENT REPORT

Client's Name: _____

Guardian's Name: _____

Name of Person Reporting: _____

Type of Incident (check all that apply):

_____ Medication Errors Not Resulting in Emergency Treatment

_____ Use of Medications for Pre-Sedation for Medical or Dental Appointments

_____ Medication Errors Involving a Pharmacy Incorrectly Filling a Prescription

_____ Use of PRN Medications Prescribed and Given as Part of a Behavioral Support Plan

_____ Injuries Not Requiring Medical Attention

Date of Incident:_____ Time: _____

Location:_____

Description of Incident: _____

_____

_____

Action Taken: _____

_____

_____

Below section is to be filled out by the agency nurse.
Who was notified about this incident? (check all that apply)

_____ Service Coordinator _____ Agency Director _____ Agency Nurse _____ Guardian

_____ Medical Practitioner _____ DS _____ APS _____ DCF

Is Follow-Up Needed?_____Yes_____No If yes, describe the follow-up plan:

_____

_____

Signature of Staff Completing Form:_____Date:_____

Agency's Nurse Signature:_____Date Notified:_____.

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