



CONFIDENTIAL FOR QUALITY ASSURANCE PURPOSES ONLY
 TO BE COMPLETED BY THE MAS NURSE (RN/LPN)
 SEND TO ADMH NDP OFFICE ONLY

Today's Date _____ Occurrence Date _____ Occurrence Time _____ A/P

Check One: Level 2 Level 3 DIVISION: DD MI SA

Client Name/Number _____
 Staff Involved _____ RN/LPN/MAC/Other* (Circle One)
 Supervising Nurse _____ RN/LPN Contacted? Y N
 Agency _____ Phone # () _____
 Location _____ (Group Home/Program Name/ County)
 Prescribing Practitioner Name _____ Contacted? Y N

NATURE OF ERROR	Medications Involved
<input type="checkbox"/> Wrong person	
<input type="checkbox"/> Wrong medicine	
<input type="checkbox"/> Wrong dose	
<input type="checkbox"/> Wrong route	
<input type="checkbox"/> Wrong time	
<input type="checkbox"/> No documentation	
<input type="checkbox"/> Wrong reason	
<input type="checkbox"/> Missed Dose	
<input type="checkbox"/> Other*	

Consumer Outcome (What happened to the consumer/)

Action(s) Taken by the Nurse

Person completing report _____ RN/LPN DATE _____

NDP OFFICE USE ONLY