

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
MEDICATION ERROR REPORT FORM



- You can use this form or you can create your own master form using this as a guide.
- All areas of this form must be completed.
- The child's parent must be notified immediately of all medication errors.
- Provider should encourage parents to notify the child's health care provider of any medication administration errors.
- The Office must be notified of all medication errors by the close of the following business day.
- If more than one child is involved in the error, an error form must be completed for each child.

Provider/Facility Name:	Facility ID Number:	Facility Telephone Number:
Child's Name:		Child's Date of Birth:
Date of Medication Error:		
<p>What type of medication error occurred:</p> <p><input type="checkbox"/> Incorrect child</p> <p><input type="checkbox"/> Incorrect medication</p> <p><input type="checkbox"/> Incorrect time (<i>gave more than 30 minutes before or 30 minutes after time authorized</i>)</p> <p><input type="checkbox"/> Incorrect dose</p> <p><input type="checkbox"/> Incorrect route</p> <p><input type="checkbox"/> Gave an expired medication</p> <p><input type="checkbox"/> Forgot to give medication</p> <p><input type="checkbox"/> Consent expired</p> <p><input type="checkbox"/> Other _____</p>		
<p>Complete this section for all errors using the information provided on the child's approved consent form (<i>except for incorrect child</i>)</p>		
Name of medication authorized:	Amount/dosage authorized:	Route of administration authorized:
<p>Frequency to be administered or signs and symptoms that necessitate the need for the medication as authorized on the consent: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
MEDICATION ERROR REPORT FORM



Describe the Incident *(include all individuals involved in the error):*

Action Taken:

OCFS notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date notified (month/day/year):	Person notified:
Parent/Guardian notified (required immediately) <input type="checkbox"/> Yes <input type="checkbox"/> No	Date notified (month/day/year):	Person notified:
Encouraged parent to notify health care provider <input type="checkbox"/> Yes <input type="checkbox"/> No	Date advised (month/day/year):	Person advised:
Other persons notified (ex: health care consultant): <input type="checkbox"/> Yes <input type="checkbox"/> No	Date notified (month/day/year):	Person(s) notified:

Describe Corrective Action Taken (indicate that an investigation will be done):

Name of person completing this form: <i>(please print)</i>	Date form completed:
Signature of person completing this form:	