



# SC Department of Disabilities and Special Needs Medication Error/Event Report

Community     Regional Center

**Provider Reporting Incident:** \_\_\_\_\_ **County:** \_\_\_\_\_

District I:  Midlands  Piedmont       District II:  Coastal  Pee Dee

**Residence of Consumer:**

- CRCF    CTH-I    CTH-II    ICF  
 SLP-I    SLP-II  
 Unit @ Regional Center

**Descriptive Location of Residence:**

(Example: Smith CTH-I, Pee Dee Center)  
\_\_\_\_\_

**Location of Incident:**

- CRCF                       Day Program  
 CTH                         ICF  
 SLP                          Unit @ Regional Center

**Descriptive Location of Incident:**

(Indicate unit name in Regional Center, provider operated facility name, i.e., Sunrise CTH-II, enclave, work activity center)  
\_\_\_\_\_

**Consumer:**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

**DOB:**

/ /  
MM/DD/YY

**Age:**

**Sex:**

- Male  
 Female

**Date of Med Error:**

/ /

**Time of Med Error:**

:  AM  PM

**Date Error Found:**

/ /

**Name & Dose of Medications Involved:**

**What type of Med Error/Event occurred: (Mark all that Apply)**

- Wrong person given the medication       Transcription error       "Near Miss" for a Med error  
 Wrong medication given                       Medication not signed off on properly       Person refused medication  
 Wrong dosage given                               Medication found                                      (Record attempts/ methods)  
 Wrong route of administration  
 Wrong time     Unsafe circumstances  
 Medication not given by staff  
 Medication given without an order

**What was the result of the Med Error/Event:**

**(At the time the Report was completed)**

- No Error (Near Miss or Red Flag Event)  
 Error, No Reaction  
 Error, Reaction, No medical Rx required  
 Error, Reaction, Medical Rx required \*  
 Error, Reaction, Death \*

**Prescriber Notified:**  Yes     No

When: \_\_\_\_\_

By Whom: \_\_\_\_\_

If no, explain: \_\_\_\_\_

**Staff Suspected of Making the Error:**

**Events Leading to Med Error/Event:**

**Name of Prescriber:**

**Name of Pharmacy:**

**Signature of Person Making Out Report/Date**

**Signature of Supervising Nurse :**

**Date:**

**Signature of Program Administrator :**

**Date:**

\*Requires the completion of Critical Incident Report per DDSN Directive 100-09-DD.