MEDICAL INCIDENT REPORT
This Report is Prepared for Purposes of Quality Improvement

Date of Incident: ________________  Time: ________  Institution: ________________

Prisoner’s Name: ________________  OBSCIS/MIS#: ________________

☐ Medication Error
Practitioner’s Order: __________________________
☐ Dose Omitted  ☐ Wrong Time
☐ Wrong Dose  ☐ Wrong Drug
☐ Wrong Patient  ☐ Transcription Error Only
☐ Non-Ordered Med  ☐ Packaging Error Only
☐ Wrong Route

Explain circumstances of incident:
__________________________________________________________________________
__________________________________________________________________________

☐ Adverse Drug Reactions
Describe reaction: __________________________
Suspected Drug/Dose/Time: __________________________
Other Medications/Dosages:
__________________________________________________________________________
__________________________________________________________________________

☐ Other Medical Incident
Describe Incident:
__________________________________________________________________________
__________________________________________________________________________

Interventions:
☐ None required  ☐ Held dose  ☐ Bed rest
Other: __________________________________________________
__________________________________________________________________________

Practitioner notified: ☐ Date: ________________  Time: ________________
Orders:
__________________________________________________________________________

Health Care Staff: __________________________  Date: ________________  Time: ________________
Name and Title

Copy to: IHCO, Pharmacy, Health Care Program Manager

Form 807.05 D rev’d 01/10/01