



# Newfoundland & Labrador Pharmacy Board

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## Sample Medication Incident Form

Patient Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Prescription Number \_\_\_\_\_  New Rx  Repeat Rx Date Dispensed \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Incident Reported To? \_\_\_\_\_  In Person  By Phone Date/Time \_\_\_\_\_

Reported By?  Patient  Doctor  Parent/Spouse  Other

- NATURE OF INCIDENT:
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Incorrect Prescriber | <input type="checkbox"/> Incorrect Drug / Strength | <input type="checkbox"/> Filled for Incorrect Patient |
| <input type="checkbox"/> Incorrect Refills    | <input type="checkbox"/> Incorrect Directions      | <input type="checkbox"/> Given to Incorrect Patient   |
| <input type="checkbox"/> Incorrect Brand      | <input type="checkbox"/> Incorrect Dosage Form     | <input type="checkbox"/> Incorrect Quantity           |
|   | <input type="checkbox"/> Drug Interaction          | <input type="checkbox"/> Outdated Medication          |
| <input type="checkbox"/> Other: _____         |  | <input type="checkbox"/> Allergy                      |

Details of Incident \_\_\_\_\_

- |  |   |
|--|---|
| Was wrong dose or wrong drug ingested? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Risk to Patient: <input type="checkbox"/> Low |
| If yes, was medical attention required? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Possible             |
| If yes, was prescriber notified? <input type="checkbox"/> Yes <input type="checkbox"/> No        | <input type="checkbox"/> High                 |

Prescriber's Comments \_\_\_\_\_

- Factors Contributing to Incident: (check all that apply)
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Illegible handwriting                 | <input type="checkbox"/> Look-alike product name  | <input type="checkbox"/> Rushing/Inattention |
| <input type="checkbox"/> Error in recording verbal Rx          | <input type="checkbox"/> Sound-alike product name | <input type="checkbox"/> Illness             |
| <input type="checkbox"/> Rx misread/misinterpreted             | <input type="checkbox"/> Look-alike product       | <input type="checkbox"/> Noise               |
| <input type="checkbox"/> Failure to clarify Rx                 | <input type="checkbox"/> DIN check failure        | <input type="checkbox"/> Interruptions       |
| <input type="checkbox"/> Incomplete patient information        | <input type="checkbox"/> Calculation error        | <input type="checkbox"/> Phones              |
| <input type="checkbox"/> Failure to verify patient information |   | <input type="checkbox"/> Shift Change        |

Details of Contributing Factors \_\_\_\_\_

Corrective Action(s) Taken \_\_\_\_\_