

- Communication Form
- Discrepancy Report

Patient Name: Patient ID: Hospital: <small>(Patient label preferred to indicate which facility and patient are involved)</small>	Date: Time:
Discrepancy Class: Order Entry Discrepancy <input type="checkbox"/> Medication Error Doses received: _____	Medication Involved: Drug Class:
What Happened? (Type of Discrepancy) <input type="checkbox"/> Wrong patient <input type="checkbox"/> Wrong drug/product <input type="checkbox"/> Wrong dose <input type="checkbox"/> Wrong directions (sig/frequency) <input type="checkbox"/> Wrong route <input type="checkbox"/> Wrong IV rate <input type="checkbox"/> Duplicate entry <input type="checkbox"/> Unapproved abbreviation <input type="checkbox"/> Med entry omitted <input type="checkbox"/> Medication not ordered <input type="checkbox"/> Med discontinued without order <input type="checkbox"/> Wrong time <input type="checkbox"/> Formulary sub not used <input type="checkbox"/> Wrong duration of therapy <input type="checkbox"/> Other: _____ _____	Contributing Factors: <i>(To be completed by Pharmacist)</i> <input type="checkbox"/> Policies <input type="checkbox"/> Legibility <input type="checkbox"/> Processes <input type="checkbox"/> Lack of Training <input type="checkbox"/> Computer Software <input type="checkbox"/> Inadequate Patient Info <input type="checkbox"/> Other: _____ _____ _____ _____ _____
Severity: <input type="checkbox"/> No Harm to Patient <input type="checkbox"/> Additional Patient monitoring needed <input type="checkbox"/> Change in Vital Signs/need for lab work <input type="checkbox"/> Treatment needed/increase in stay <input type="checkbox"/> Intensive Medical Care <input type="checkbox"/> Permanent Patient Harm Cause or contribute to Death	Comments/Communication: _____ _____ _____ _____ _____ _____ _____ _____ Signature: _____