



USP MEDICATION ERRORS REPORTING PROGRAM

Presented in cooperation with the Institute for Safe Medication Practices
 The USP Practitioners' Reporting NetworkSM is an FDA MEDWATCH partner

ACTUAL ERROR POTENTIAL ERROR

Please describe the error. Include sequence of events, personnel involved, and work environment (e.g., code situation, change of shift, short staffing, no 24-hr. pharmacy, floor stock). If more space is needed, please attach separate page.

Was the medication administered to or used by the patient? No Yes Date and time of event: _____

What type of staff or health care practitioner made the initial error? _____

Describe outcome (e.g., death, type of injury, adverse reaction). _____

If the medication did not reach the patient, describe the intervention. _____

Who discovered the error? _____

When and how was error discovered? _____

Where did the error occur (e.g., hospital, outpatient or retail pharmacy, nursing home, patient's home)? _____

Was another practitioner involved in the error ? No Yes If yes, what type of practitioner? _____

Was patient counseling provided? No Yes If yes, before or after error was discovered? _____

If a product was involved, please complete the following:

	Product #1	Product #2
Brand name of product involved	_____	_____
Generic name	_____	_____
Manufacturer	_____	_____
Labeler (if different from mfr.)	_____	_____
Dosage form	_____	_____
Strength/concentration	_____	_____
Type and size of container	_____	_____
NDC number	_____	_____

If available, please provide relevant patient information (age, gender, diagnosis, etc.). Patient identification not required.

Reports are most useful when relevant materials such as product label, copy of prescription/order, etc. can be reviewed.

Can these materials be provided? No Yes If yes, please specify. _____

Suggest any recommendations you have to prevent recurrence of this error or describe policies or procedures you have instituted to prevent future similar errors.

A copy of this report is routinely sent to the Institute for Safe Medication Practices (ISMP), to the manufacturer/labeler, and to the Food and Drug Administration (FDA). **USP may release my identity to: (check boxes that apply)**

ISMP The manufacturer and/or labeler as listed above FDA Other persons requesting a copy of this report Anonymous to all

Your name and title _____ Telephone number _____
 Your facility name, address, and ZIP _____ (include area code)

Signature _____ Date _____

Return to the attention of:
 Diane D. Cousins, R.Ph.
 USP PRN
 12601 Twinbrook Parkway
 Rockville, MD 20852-1790

Call Toll Free: **800-23-ERROR** (800-233-7767)
 or FAX 301-816-8532
 USP home page: <http://www.usp.org/prn>

Date Received by USP:

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