## Department of Public Health Drug Control Program Drug Incident Report

Pursuant to the Department's regulations at 105 CMR 700.005(D), registrants are required to report the loss of any controlled

Please note that any box framed in red is a 'mandatory' field - it must be filled in before submitting the report.

			ndly fill out this incident re scovery. Do not include a				
Date of Report		Report Prepared By					
Title		Contact's Phone (10 digit number) Contact's Phone (10 digit number)		Contact's e-m	Contact's e-mail		
Facility Information		<u>I</u>	·				
Facility Name/Serv	/ice Provider		•				
Address			_				
City Facility Type			County	Zip	Code	+ 4	
Date of Loss		Specific location of loss (unit, floor, etc., if applicable)					
Opecine location of loss (unit, moof, etc., if applicable)							
Incident Type		ļ.					
□ Diversion	☐ Loss	□ Theft	□ Tampering	■ Documentation			
Other (Please S							
List drugs (use addi	itional entries on the l	back of this form	if necessary)				
To select a drug begin typ time. If the drug you are the drug.	oing in the name of the drue looking for does not a	ug (brand or generion appear, you may e	c). As the options narrow, senter 'other' - whereupon a	elect the correct dru text box will open	ig from the drop up for you to ε	o down list at any enter the name of	
Once you have entered/se 'locked out' until a drug ha	elected a drug, hit the 'tab s been selected.	' key to move to the	e 'Qty' box. Please note that	the Qty, Strength a	nd Dosage Forr	n boxes will be	
Drug				Qty	Strength	Dosage Form	
		<del>.</del>	·	·			
					l	]	
		•	<u> </u>	·			
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			ay have contributed to		her relevant i	nformation.	
Please indicate if pa	atient narm was invoi	ved. Please use	additional sheets if nec	essary.)			

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