MEDICATION OCCURRENCE REPORT (MOR)

1. Name of Individual: _____
2. Street Address: _____
3. Phone number at the program: _____
4. Program Director Name: _____

Who completed form?: _____
Reviewer: _____
(signature)
Reviewer: write additional comments on the back

5. What happened? (Check one)
   ☐ Omission ☐ Wrong time ☐ Wrong Route ☐ Wrong Dose
   ☐ Wrong Person ☐ Wrong Medication
6. Date of medication occurrence: _____ Time: _____ am or pm?
7. Date of discovery of the error: _____ Time: _____ am or pm?
8. Did the medication occurrence happen over multiple consecutive administrations? Yes No
9. If yes in number 8, over what number of doses did the medication occurrence happen? _____
10. Position of the person who gave the medication : (Check one)
    ☐Direct Care ☐ Supervisor ☐ Other
11. Was the person who gave the medication MAP certified? Yes No
12. Please describe what happened:
    _____
    _____
    _____
13. MAP consultant's title: ☐ Registered Nurse ☐ Registered Pharmacist ☐ Health Care Provider
14. Name of consultant contacted : _____
15. Date consultant contacted: _____ Time: _____ am or pm?
16. Was medical intervention recommended? Yes No
17. If yes in number 16, Check all that apply:
    ☐ Lab work ☐ Other tests ☐ Health Care Provider visit ☐ Clinic visit
    ☐ Emergency room visit ☐ Hospitalization
18. Did any of the following situations or conditions result from the medication occurrence (Check all that apply)
    ☐ Illness ☐ Injury ☐ Death
19. Was DPH notified? ☐ Yes ☐ No
20. Date DPH was notified: _____ Time: _____ am or pm?
21. Was an Incident Report filed as a result of the medication occurrence? Yes No
22. What has been done to prevent this from happening in the future? (training, review, change in systems, etc.)
    _____
    _____
    _____
23. What medications was the person supposed to get?

Name of medication	Dosage	Frequency/Time	Route

24. What medications did the person get? (If medication was omitted, please write NONE)

Name of medication	Dosage	Frequency/Time	Route

25. Number of medications supposed to be given at the same time as the medication occurrence (include the medication(s) involved in the medication occurrence (check one)
    ☐1 ☐2 ☐3 ☐4 ☐5 ☐6-10 ☐ 11-15
26. Was there a recent change in the medication order for the medication(s) involved in the MOR? Yes No
27. If yes in number 26, date of medication order change: _____
28. Can this medication occurrence be connected to a single staff person? Yes No **If Yes, answer #29--33**
29. Who made the medication error? _____
30. Status of the person who made the error: ☐ Regular staff member ☐ Temp. agency staff ☐ FH Relief staff
31. Does the person who made the error regularly give medications? Yes No
32. Was the person who made the error working their regular shift? Yes No
33. Was the person who made the error working at their routine site? Yes No

Please write additional information on the back of this form.