

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION ERROR REPORT

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

CHILD'S NAME (LAST, FIRST, MI.):		
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:

To be recorded by Health Care Integration Agency (HCIA) staff or Waiver Service Provider (WSP) staff for all medication errors. This report should be made available if requested by Office of Children and Family Services (OCFS).

Date of Error:

Describe Medication Error Type:

<input type="checkbox"/> Medication
<input type="checkbox"/> Dosage
<input type="checkbox"/> Routing
<input type="checkbox"/> Dosage Timing
<input type="checkbox"/> Frequency

HCIA OR WSP NAME:	HCIA OR WSP SIGNATURE: X	DATE:
HCIA OR WSP SUPERVISOR'S NAME:	PHONE #:	
HCIA NAME:		
HCIA OR WSP ADDRESS:	CITY:	STATE: ZIP CODE: