



**MEDICATION DEVIATION FORM**  
**\*Must be submitted w/in 24 hours of deviation\***

**SECTION A**

CUSTOMER: \_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

CHECK ALL OF THE FOLLOWING THAT APPLY TO THIS DEVIATION:

- CUSTOMER REFUSAL
- DOSAGE MISSED/NOT GIVEN
- MED DELAYED BY MORE THAN ONE HOUR
- INCORRECT DOSAGE

MEDICATION	CORRECT DOSE/ACTUAL DOSE	CORRECT TIME/ACTUAL TIME	PRIMARY SIDE EFFECT(S)
_____	_____/_____	_____/_____	_____
_____	_____/_____	_____/_____	_____
_____	_____/_____	_____/_____	_____
_____	_____/_____	_____/_____	_____

WHAT IS THE MEDICATION USED FOR?  
\_\_\_\_\_  
\_\_\_\_\_

COMPLETE SECTION B FOR ALL DEVIATIONS EXCEPT FOR CUSTOMER REFUSALS.

**SECTION B**

Explain the deviation in detail: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Who was contacted regarding deviation? \_\_\_\_\_

What was their recommendation? \_\_\_\_\_

How could this deviation have been avoided? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PERSON FILLING OUT FORM

\_\_\_\_\_  
PERSON RESPONSIBLE FOR ERROR (IF DIFFERENT)

*PLEASE SUBMIT A COPY OF THIS FORM TO SERVICE COORDINATOR AND AGENCY NURSE.*

Date Reviewed by Service Coordinator: \_\_\_\_\_

Follow Up by Agency Nurse: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_