DIDD MEDICATION VARIANCE REPORT

NAME ______________________ **SS#** ____________ **AGE** _____ **M**☐ **F**☐ **AGENCY** ______________________

DATE VARIANCE OCCURRED __________ **DAY OF WEEK** Sun☐ Mon☐ Tue☐ Wed☐ Thu☐ Fri☐ Sat☐ **WEEKEND/HOLIDAY** Y☐ N☐

TIME 6a☐ 7a☐ 8a☐ 9a☐ 10a☐ 11a☐ 12n☐ 1p☐ 2p☐ 3p☐ 4p☐ 5p☐ 6p☐ 7p☐ 8p☐ 9p☐ 10p☐ 11p☐ 12a☐ 1a☐ 2a☐ 3a☐ 4a☐ 5a☐

LOCATION Home☐ Day Program☐ Community☐ Work☐ Other☐ ______________________

STAFF CLASSIFICATION
Nurse☐ Pharm☐ Physician☐ DSS☐ Other☐

STAFF STATUS
Regular☐ Agency/Contract☐ Float/PRN☐ *Not Certified/Unlicensed☐

DRUG/DOSE Ordered ______________________

DRUG/DOSE Administered ______________________

HIGH ALERT MEDICATION Y☐ N☐

ALLERGIC Y☐ N☐

WRONG
Person☐ Med/Drug☐ Time☐ Position☐ Texture/Formulation☐ Documentation☐ Dose☐ extra☐ omitted☐ Route☐ PO☐ SC☐ IM☐ IV☐ Topical☐ Rectal☐ Vaginal☐ Tube☐ Trach☐ Other☐

DATE VARIANCE DISCOVERED ______________ **FACTORS** Product☐ Med Use System☐ Communication☐ Other☐ __________

DESCRIPTION Prescribing☐ Dispensing☐ Transcribing☐ Administering☐ Procurement/Storage☐ Monitoring☐

COMMENTS ____

CATEGORY

Potential
A☐ Could result in a variance
B☐ Identified prior to actual administration

Actual
*C☐ No harm or unlikely to cause harm
*D☐ Additional monitoring

Actual
* E☐ Intervention (practitioner/ER)
* F☐ Hospitalization
* G☐ Permanent harm
* H☐ Near death event
* I☐ Death

PRACTITIONER NOTIFIED Y☐ N☐
* **Required for C-I**

REPORTABLE INCIDENT FORM COMPLETED Y☐ N☐
* **Required for E-I**
* **Required for Not Certified/Unlicensed**

INVESTIGATOR NOTIFIED Y☐ N☐
* **Required for Not Certified/Unlicensed**

____
Signature/Title Date

OUTCOME ____

____

____
Signature/Title Date

DIDD-0484 **Revised 1-15**