

Michelle P Waiver

Medication Error Report (Part 1)

Instructions: This report must be submitted each month by any provider supporting Michelle P individuals. Do not include data for individuals receiving supports through state general funds or SCL. This report should be addressed to: SCL/Michelle P Risk Management Team, Division of Mental Retardation, 100 Fair Oaks Drive, 4W-C, Frankfort, Kentucky 40621. The report should be postmarked by the 15th of the month. Or, click the email button below and the form will automatically be emailed to the risk management team and sent to your default printer.

For the month of : ,

Provider Name:

Provider Number:

Number of Michelle P Individuals Supported:

Doses of medications planned to be administered to Michelle P individuals:

Total number of doses for which there was a referenced error:

Date the report was submitted:

To see your Medication Error Rate place your cursor over the field below, right click, and select update field.

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Click the button to the right to

Or email as an attachment to dmr.complaints@ky.gov

Or fax to (502)564-8917

Email Transmission is preferred.



Michelle P Waiver

Medication Error Report (Part 2)

Instructions: This report must be submitted each month only for Michelle P individuals for whom a dose or doses of medication were referenced as being administered in error. A separate page should be completed for each individual. In the event that there are more than fifteen errors referenced for an individual, continue on the next page and combine your data for the individual's monthly error statistics. Medication Errors for individuals supported through state general funds should be reported on a State General Funds Medication Error Report. This report should be addressed to: SCL/Michelle P Risk Management Team, Division of Mental Retardation, 100 Fair Oaks Drive, 4W-C, Frankfort, Kentucky 40621. The report should be postmarked by the 15th of the month. Or, click the appropriate button below and the form will automatically be emailed to the risk management team and sent to your default printer. This form should contain enough space to document errors for five individuals. If you have errors for more than five individuals please click the button to submit this form then reopen the form and input data for the next five individuals with medication errors. Continue this process until all errors have been documented.

Provider Name: Provider Number: For the Month of: ,

Click the button to the right to

Or email as an attachment to dmr.complaints@ky.gov

Or fax to (502)564-8917

Email Transmission is preferred.



Individual Name: Social Security #:

Medication	Dosage	Frequency	Date and Time of Error	Administration Site	Type of Error	Staff Member Responsible	Agency Follow-up
				Click here to Select Site	Click Here to Select Type		
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				Click here to Select Site	Click Here to Select Type		
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Total doses of medication which were administered in error this month for this individual:

Total doses of medication planned to be administered to this individual this month:

To see this individual's Medication Error Rate place your cursor over the field to the right,, right click, and select update field.



Individual Name: Social Security #:

Medication	Dosage	Frequency	Date and Time of Error	Administration Site	Type of Error	Staff Member Responsible	Agency Follow-up
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