Green Mountain Support Services
PRN Psychotropic Medication Administration Incident Report

Date: _____Client: _____DOB: _____Allergies: _____

Service Coordinator: _____Date/Time notified: _____/_____

PRN Psychotropic Medication Administration Incident Report

Medication, dose, route administered: _____Time administered: _____

Interventions attempted prior to medication administration: _____
_____
_____

Reason(s) medication administered: _____
_____

Outcomes (Please check one):

___Resolved/therapeutic effect ___Partial improvement___ No improvement ___ Adverse effect

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Outcomes (Please check one):

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_____ _____
Individual Reporting Incident (Sign & Date) Service Coordinator (Sign & Date)

_____ _____
Supervisor / Leadership (Sign & Date) Agency Nurse (Sign & Date)

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