DATAFORM 4
ADE Incident Identification Form

1. Study ID Number: ___ ___-___ ___ ___ ___ ___

2. Case Number: ___ ___ ___ ____

3. Reviewer ID Number: ___ ___

4. Brief description of ADE: _____

5. Indicate the prescription number   ____ . ____

6. Category of complication   ____
   1. Bleeding
   2. CNS
   3. Allergic/cutaneous
   4. Metabolic
   5. Cardiovascular
   6. GI
   7. Renal
   8. Respiratory
   9. Marrow Depression
   10. Other _____
   11. Eyes
   12. Ears
   13. Nose
   14. Throat
   15. Reproductive
   16. Musculoskeletal
   17. Skin

7. How long did it last?   ____
   1. Less than one day
   2. 1-3 days
   3. 4-7 days
   4. 8 days to 1 month
   5. More than 1 month
   6. Unknown
   7. Disabling
   8. Lab abnormality only

8. Was there any other evidence of   ____
   the ADE? *(eg. Endoscopy showing ulcer)*
   1. No
   2. Yes, specify: _____
   3. Don't know

9. Was the drug stopped?   ____
   1. No
   2. Yes
   3. Don't know
   4. Not applicable

10. Did this adverse drug event result in an additional visit?	_____
	1. No *(Skip to question Q12)* 2. Yes *(Go on to Q11)*
11. If yes, how many of each visit (indicate all that apply)	1. _____ Clinic visits 2. _____ Emergency room visits 3. _____ Hospital admissions 4. _____ Admissions to long-term facility 5. _____ Phone call 6. _____ Email contacts 7. _____Other_____ 8. _____Other _____
12. Was the event caused by a medication that required outpatient blood monitoring?	_____
	1. No *(Skip to Q14)* 2. Yes *(Go on toQ13)*
13. If yes, was there elevated/abnormal level with the event?	_____ _____ _____
	1. No 2. Yes (specify level and abnormality)
14. Was there regular monitoring of the blood level prior to the event?	_____
	1. No 2. Yes

15. Relevant lab values: (at visit or most recent prior to visit)

Test name	Value	Date
a.		
b.		

16. Was this incident due to a medication   ____   1. No *(STOP, form is complete)*

error?
2. Yes *(Go on to question 17)*
3. Unknown *(STOP, form is complete)*

17. Category of reason *(multiples may be checked; circle primary reason):*

     ____ 1. Illegible Order   If yes:

____	1.01	MD signature illegible
____	1.02	Patient name illegible
____	1.03	Med name illegible
____	1.04	Illegible route
____	1.05	Illegible frequency
____	1.06	Illegible length of treatment
____	1.07	Illegible amount to be dispensed
____	1.08	Entire prescription illegible
____	1.09	Illegible dose or dose units
____	1.10	Illegible strength or strength units
____	1.11	Illegible date
____	1.12	Illegible weight or weight
____	1.13	Illegible directions for use

     ____ 2. Dose error   If yes:

____	2.01	Overdose
____	2.02	Underdose
____	2.03	Dose omitted (from order/when dispensed)
____	2.04	Dose units omitted
____	2.05	Dose form incorrect
____	2.06	Extra dose(s)
____	2.07	Missed dose(s) (not given/taken)
____	2.08	Discrepancy in dose

     ____ 3. Route error   If yes:

____	3.01	Route omitted
____	3.02	Route incorrect
____	3.03	Discrepancy in route

     ____ 4. Frequency error   If yes:

____	4.01	Frequency omitted
____	4.02	Frequency incorrect
____	4.03	Discrepancy in frequency

_____ 5. Length of Treatment Error   If yes:

              _____   5.01   Length of treatment omitted

              _____   5.02   Length of treatment incorrect

              _____   5.03   Discrepancy in length of treatment

_____ 6. Directions Error   If yes:

              _____   6.01   Directions for use omitted

              _____   6.02   Directions for use incorrect

              _____   6.03   Directions for use incomplete

              _____   6.04   Discrepancy in directions

_____ 7. Strength Error   If yes:

              _____   7.01   Strength omitted

              _____   7.02   Strength incorrect

              _____   7.03   Strength incomplete

              _____   7.04   Strength without units

_____ 8. Amount to be dispensed error   If yes:

              _____   8.01   Amount to be dispensed omitted

              _____   8.02   Amount to be dispensed incorrect

              _____   8.03   Amount to be dispensed without units

_____ 9. PRN without indication

_____ 10. Weight Error   If yes:

              _____   10.01 Weight omitted

              _____   10.02 Weight incorrect

              _____   10.03 Weight units missing

_____ 11. Date Error   If yes:

              _____   11.01 Date omitted

              _____   11.02 Date incorrect

____ 12. Inappropriate use of   If yes
        abbreviation

               ____ 12.01 Dose abbreviation
               ____ 12.02 Route abbreviation
               ____ 12.03 Frequency abbreviation
               ____ 12.04 Length of treatment abbreviation
               ____ 12.05 Directions abbreviation
               ____ 12.06 Strength abbreviation
               ____ 12.07 Amount abbreviation
               ____ 12.08 Weight abbreviation

____ 13. Other, specify: _____

____ 14. Substitution   If yes:

               ____ 14.01 Wrong drug given
               ____ 14.02 Wrong patient received drug
               ____ 14.03 Wrong drug ordered
               ____ 14.04 Other _____

____ 15. Refill Error

____ 16. Failure to recognize drug-drug interaction

____ 17. Inadequate follow-up of therapy

____ 18. Use of inappropriate drug

____ 19. Avoidable delay of treatment

____ 20. Patient had documented allergy to medication prescribed

18. Person Primarily Responsible   ___

1. Physician
2. Nurse practitioner
3. Physician's assistant
4. Nurse in office
5. Pharmacist in office
6. Pharmacist in pharmacy
7. Parent/Legal guardian
8. School nurse
9. Babysitter/daycare provider
10. Patient
11. Other_____
12. None
13. Insurance
14. Person who takes phone orders
15. LMR

19. Other people responsible   ___ ___ ___
1. Physician
2. Nurse practitioner
3. Physician's assistant
4. Nurse in office
5. Pharmacist in office
6. Pharmacist in pharmacy
7. Parent/Legal guardian
8. School nurse
9. Babysitter/daycare provider
10. Patient
11. Other _____
12. None
13. Insurance
14. Person who takes phone orders
15. LMR

20. Any work resulting from Medication Error?
   (Choose all that apply)

____ 1. Patient contacted provider (phone)
____ 2. Patient contacted provider (email)
____ 3. Patient contacted RN (phone)
____ 4. Patient contacted RN (email)
____ 5. Provider contacted pharmacy
____ 6. Pharmacy contacted provider
____ 7. Patient contacted pharmacy
____ 8. Labs
____ 9. Office visit
____ 10. ED visit
____ 11. Hospitalization
____ 12. Consults
____ 13. Other medications
____ 14. Other, specify: _____
____ 15. None

21. At what level did this error occur?
   (Choose all that apply)

____ 1. Physician order
____ 2. Pharmacy dispensing
____ 3. Transcription
____ 4. Patient administration
____ 5. Monitoring
____ 6. Can't tell

22. Was the error intercepted?

____ No
____ Yes

23. If intercepted, then by whom?   ___ ___ ___ ___ ___

          1. Physician
          2. Nurse Practicioner
          3. Physician Assistant
          4. EMR
          5. Pharmacist in office
          6. Pharmacist in pharmacy
          7. Parent/legal guardian
          8. School nurse