McLaren Medical Group

ADVERSE DRUG REACTION REPORT

Section #1 (To be Completed by Physician/Nurse/MA):

Site: _____

Date: _____ / _____ / _____ Time: _____ a.m. / p.m.

Suspected medication(s), including strength: _____

_____

Description of suspected reaction: _____

_____

Ordering physician notified: ❑ Yes ❑ No

Disposition /other treatment ordered: _____

_____

_____

_____

Individual reporting observation/intervention signature: _____ Date: ____ / ____ / ____

Physician's signature: _____ Date: ____ / ____ / ____

Section #2 (To be Completed by Performance Improvement and/or Safety Officer):

Comments: _____

_____

_____

_____

_____

_____

Disposition: _____

_____

Performance Improvement Manager signature: _____ Date: ____ / ____ / ____

Safety Officer signature: _____ Date: ____ / ____ / ____

Section #3 (Review by Ambulatory Quality Improvement Committee):

Comments: _____

_____

_____

_____

_____

_____

Disposition: _____

_____

Chairperson signature: _____ Date: ____ / ____ / ____