Client Name: DESTINY MANAGEMENT

ADVERSE REACTION REPORT

Note: Significant adverse reactions require immediate report to the client's physician or pharmacist.

Date of the adverse reaction: _________________ Time: _________________

Describe the adverse reaction: ___________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Person/Title of individual observing adverse reaction: _______________________________

Physician or Pharmacist notified: ____________________________ Date: _________ Time: ______

Recommendation/Direction from Physician or Pharmacist: ___________________________
____________________________________________________________________________
____________________________________________________________________________

Documented in service notes: _____Yes  _____No

Documented on front of record: _____Yes  _____No

Documented on the MAR: ___Yes  ___No

Staff Notifications: Signature ____________________________   Date ____________

Signature ____________________________   Date ____________

Signature ____________________________   Date ____________

Notifications – Other: Legally Responsible Person
Name: ____________________________ Date ____________

Care Coordinator
Name: ____________________________ Date ____________

Staff Signature/Position Title/Degree/Licensure   Date