Client Name:		**DESTINY MANAGEMENT** **ADVERSE REACTION REPORT**
Record #:	**DOB:**	

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