

**Department of Public Health
Drug Control Program
Drug Incident Report**

Pursuant to the Department's regulations at 105 CMR 700.005(D), registrants are required to report the loss of any controlled substances upon discovery. When a drug loss is discovered, kindly fill out this incident report and fax it to the Drug Control Program at (617) 753-8083 within twenty four hours of discovery.

| | | | | |
|--|------------------------------------|---|--|---|
| Date of Report | | Report Prepared By | | |
| Title | | Contact's Phone Number | Contact's e-mail | |
| Facility Information | | | | |
| Facility Name _____ | | | | |
| Address _____ | | | | |
| City _____ | | Zip Code _____ | | |
| Facility Type | | | | |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> MAP (DDS) | <input type="checkbox"/> Clinic | <input type="checkbox"/> Ambulance | <input type="checkbox"/> Manufacturer/Distributor |
| <input type="checkbox"/> Long Term Care | <input type="checkbox"/> MAP (DMH) | <input type="checkbox"/> Prison/House of Correction/Jail | <input type="checkbox"/> Practitioner's Office | |
| <input type="checkbox"/> School | <input type="checkbox"/> MAP (DCF) | <input type="checkbox"/> VNA | | |
| <input type="checkbox"/> Other (Please Specify) _____ | | | | |
| Date of Loss | | Specific location of loss (unit, floor, etc., if applicable) | | |
| Incident Type | | | | |
| <input type="checkbox"/> Diversion | <input type="checkbox"/> Loss | <input type="checkbox"/> Theft | <input type="checkbox"/> Tampering | <input type="checkbox"/> Documentation |
| <input type="checkbox"/> Other (Please Specify) _____ | | | | |
| Drug (use additional sheets if needed) | Quantity | Strength | Dosage Form | |
| _____ | _____ | _____ | _____ | |
| _____ | _____ | _____ | _____ | |
| _____ | _____ | _____ | _____ | |
| Narrative (Please explain what happened, what factors may have contributed to loss, and any other relevant information. Please indicate if patient harm was involved. Please use additional sheets if necessary.) | | | | |
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|----------------------------|----------------|---------------|-------------------------|
| For office use only | | | |
| Received by Drug Unit | Staff initials | Intake number | Date facility contacted |