

**FORM 1201-C**

**NH Bureau of Developmental Services Six-Month Area Agency Report to Medication Committee**

1. Area Agency Name: _____ Area Agency Address: _____ Area Agency Address: _____  Area Agency Contact person: _____ Email address: _____ Phone number: _____	2. Number of programs where medications are administered by unlicensed persons: 1001 _____ 521 _____ 507 _____ 524 _____ 518 _____ 525 _____
3. Number of Psychotropic Medications prescribed: _____	4. Number of individual identified to be in Frail Health: _____

TO:  
 Jen McLaren, M.D.  
 Chairperson, Medication Committee  
 c/o Stacy Colby, Bureau of Developmental Services  
 105 Pleasant Street, Main Bldg. Rm. 125 S.  
 Concord, NH 03301

Dear Dr. McLaren,

Enclosed are the semi-annual medication administration review He-M 1201 A, B and C Form(s) for the period of \_\_\_\_\_ through \_\_\_\_\_, including each provider agency's and/or area agency entity's performance summarized, and this corresponding area agency's plan for monitoring, oversight, and quality improvement. In addition, from this Area Agency's perspective:

5. Summary Medication Errors:

Wrong Medication	
Wrong Time	
Wrong Dosage	
Wrong Person	
Wrong Route	
Omission	
Documentation	

Total Errors	
Number of doses	
Error to dosage ratio	
Number of He-M 1201 authorized providers*	

\*Providers may be authorized in more than one location and therefore may be counted more than once.

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- 6. Positive Regional Trends:
  
- 7. Negative Regional Trends and Corrective Actions:
  
- 8. Significant Changes in Individuals' Health Status, if any, and Actions Taken:
  
- 9. Oversight of Vendor-specific Issues, including Oversight of Area Agency Entity Issues if any:
  
- 10. Quality Improvement Initiatives or Plans for Monitoring:
  
- 11. Patterns of Non-Compliance, if any:

12. Signature of individual completing form: (electronic signatures cannot be accepted at this time)	Date:
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