STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
DRUG CONTROL DIVISION
450 COLUMBUS BLVD
HARTFORD, CT 06103
Fax: (860) 706-1350
Phone: (860) 713-6065

Please e-mail completed form to dcp.rxerror@ct.gov

Consumer Complaint Form

Please fill this form out as completely and accurately as you can. Thank you.

Name of Person Registering Complaint:	**Phone Number:**	**Email Address**	
Address:	**City:**	**Zip Code:**	
Patient Name (if different):	**Patient Date of Birth:**	**Relationship to Patient (if applicable:)**	
Name of Pharmacy:			
Address of Pharmacy:	**City:**	**State:**	**Zip Code:**
Date the Prescription Was Filled:	**Date the Issue Was Found**		
Prescription Number (if applicable):	**Medication Prescribed (Name & Strength):**		
Medication Dispensed (name & strength):	**Pharmacist Name (if known):**		

Have you discussed this matter with the pharmacist or a pharmacy representative? ☐ **Yes** ☐ **No**
If yes, on what date_____

If complaint involves a prescription error, is the evidence available? ☐ **Yes** ☐ **No**
If yes, where is the evidence? _____

Has the pharmacy been contacted about this error? ☐ **Yes** ☐ **No**
If yes, on what date_____

Type of Error (please select the error type(s) that are most similar to your situation:

☐ **Wrong Medication**	☐ **Expired Medication**	☐ **Other**_____
☐ **Wrong Patient Name**	☐ **Mixed Medication**	
☐ **Wrong Strength**	☐ **Received someone else's medication**	
☐ **Wrong Directions**		
☐ **Wrong Quantity**		

Briefly describe the events related to the complaint in the order in which they happened: