STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
DRUG CONTROL DIVISION
165 CAPITOL AVE.
HARTFORD, CT 06106
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 ☐ Wrong Patient Name ☐ Wrong Strength ☐ Wrong Directions ☐ Wrong Quantity	☐ Expired Medication ☐ Mixed Medication ☐ Received someone else's medication	☐ Other___________________________

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