

Have you discussed this matter with the pharmacist or a pharmacy representative? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of person contacted:			Date of contact:
How was contact made: <input type="checkbox"/> By phone <input type="checkbox"/> By letter <input type="checkbox"/> In person			
Result of contact:			
FURTHER INFORMATION (Complete only if applicable)			
Prescribing doctor:			Telephone number
Address of doctor:		City	State Zip code
Medication prescribed	Medication received	Prescription number	
The medication was: <input type="checkbox"/> for a new prescription <input type="checkbox"/> a refill <input type="checkbox"/> a new prescription for a medication taken or used previously.			
Was there harm to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe briefly:			
Did the pharmacist consult with you regarding your medication at the time it was dispensed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Was any of the medication taken or used? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you still have the medication? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you still have the container/label? <input type="checkbox"/> Yes <input type="checkbox"/> No If you have the medication and/or container, please retain them until further notified by a board inspector.			
If this complaint is against an individual licensed by the board of pharmacy, would you be willing to testify against the individual? <input type="checkbox"/> Yes, I would be willing to testify. <input type="checkbox"/> No, I would not be willing to testify.			
If applicable, please attach to this form COPIES of any papers involved (prescription, bills/invoices received, cancelled checks, correspondence, etc.). DO NOT SEND ORIGINALS.			

Signature

Date