Oregon
Kate Brown, Governor

Oregon Board of Pharmacy
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CONSUMER COMPLAINT FORM

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

Name of Person Registering Complaint:	Name of Patient:		
Address:	City	State	Zip Code
Work telephone number	Home telephone number	Relationship to patient	
Name of pharmacy			
Address of pharmacy:	City	State	Zip Code
Name of pharmacist (if known):	Name of other person involved (if known):		
When did the problem occur?			

DETAILS OF COMPLAINT

Describe the events related to the complaint in the order in which they happened. Include dates. If wrong drug was dispensed describe the color/shape/imprint code of the drug dispensed. If information on the label was incorrect (patient name, directions for use, prescriber's name, etc.) describe the information printed on the label and what it should have been. (Use extra sheets if necessary.)

Have you discussed this matter with the pharmacist or a pharmacy representative? ☐ Yes ☐ No			
Name of person contacted:			Date of contact:
How was contact made: ☐ By phone ☐ By letter ☐ 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: ☐ for a new prescription ☐ a refill ☐ a new prescription for a medication taken or used previously.			
Was there harm to the patient? ☐ Yes ☐ No If yes, describe briefly:			
Did the pharmacist consult with you regarding your medication at the time it was dispensed? ☐ Yes ☐ No			
Was any of the medication taken or used? ☐ Yes ☐ No			
Do you still have the medication? ☐ Yes ☐ No			
Do you still have the container/label? ☐ Yes ☐ 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? ☐ Yes, I would be willing to testify. ☐ 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 _____