



## Complaint Form

In order to ensure the receipt of comprehensive written details, the PEI College of Pharmacy requests the completion of this form when filing a complaint.

By completing this Complaint Form you:

1. Acknowledge that you are lodging a written formal complaint and understand that the College will investigate all written formal complaints; and
2. Give permission to the College to access your pharmacy records and request and receive copies of all medical and pharmacy related records related to the complaint; and
3. Give permission to the College to discuss and/or release part or all of the Complaint Form and all supporting documentation with any person(s) named in the complaint, or any person(s) deemed necessary in the investigation of the complaint; and
4. Certify that the details and information provided are true, accurate and complete to the best of your knowledge.

If you have any questions concerning the above, require assistance, or would like to speak with College staff before completing this complaint, please contact the PEI College of Pharmacy.

### 1. Person Filing Complaint

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

### 2. Patient Information

Patient Name (if different from above): \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

If you are not the patient or the person directly involved in the incident, please describe your relationship to that individual (parent, spouse, child, relative, health professional, lawyer or friend):

\_\_\_\_\_  
Please be advised that if you are filing a complaint on behalf of another individual, the College may require the individual to provide consent to access personal information relating to the complaint. Please complete the consent form below and forward to the PEI College of Pharmacists with this complaint form.

### 3. Pharmacy Information



PRINCE EDWARD ISLAND  
**COLLEGE OF PHARMACY**

Member organization of National Association of Pharmacy Regulatory Authorities (NAPRA)

Name of Pharmacy: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Pharmacist (if known)  
: \_\_\_\_\_

#### 4. Nature of the Complaint

**MEDICATION ERROR (for Medication Errors, please also fill in all of the details below)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Incorrect Patient  | <input type="checkbox"/> Incorrect Quantity    | <input type="checkbox"/> Incorrect Doctor           |
| <input type="checkbox"/> Incorrect Drug     | <input type="checkbox"/> Incorrect Directions  | <input type="checkbox"/> Out-of-date drug dispensed |
| <input type="checkbox"/> Incorrect Strength | <input type="checkbox"/> Incorrect Dosage-form |   |

If available, provide a copy of the Prescription Label, OR provide the details from the Prescription Label:

1. Prescription Number: \_\_\_\_\_

2. Date of Issue: \_\_\_\_\_

3. Drug Name: \_\_\_\_\_

4. Physician Name: \_\_\_\_\_

5. Directions: \_\_\_\_\_

How was the incident discovered: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Who discovered the incident: \_\_\_\_\_

When was the incident discovered: \_\_\_\_\_

Was the incident reported to the pharmacy? If so when: \_\_\_\_\_

What was the outcome of the incident when reported:  
\_\_\_\_\_  
\_\_\_\_\_



