COMPREHENSIVE INTERVENTIONAL CARE CENTERS

Compliance Use Only:				
1	2	3	4	5

Patient Complaint Form

Must be filled out completely by director/manager upon notice of complaint.

Facility/Department: _____ Address: _____

TODAY'S DATE		**DIRECTOR / MANAGER NAME**
PATIENT NAME		**MRN**
DATE INCIDENT OCCURRED	**TIME OF INCIDENT**	**HEALTH INSURANCE CLAIM NUMBER**

EMPLOYEE(S) INVOLVED IN COMPLAINT:

_____

_____

EMPLOYEE(S) WORKING AT TIME OF COMPLAINT:

_____

_____

PERSON NOTIFIED OF COMPLAINT:

_____

_____

DESCRIPTION OF COMPLAINT:

_____

_____

_____

_____

_____

CORRECTIVE ACTION:

_____

_____

_____

FOLLOW UP:

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Director/Manager Signature Date