COMPLAINT FORM

Date the complaint was received: _____

Name of patient: _____

Name of person filing the complaint if not the patient: _____

Relationship to the patient: _____

Name/title of who received the initial complaint: _____
Date: _____

Was the complaint logged? □ Yes □ No

Description of the complaint: _____
_____
_____
_____

Resolution of the compliant (action taken}: _____
_____
_____

Follow up needed:
_____
_____

Was the person making the complaint satisfied with the resolution and/or action plan?
□ Yes □ No

If no what follow up was implemented? _____

I have reviewed and ensured the implementation related to this complaint including any follow up needed that is needed.

Signature and title _____

Date _____