CLIENT/PATIENT
Complaint/Grievance Form

Location: ______________________ Date: ____________

Patient Name: ______________________ HIC/ID: __________ Time: __________

M.D. Name: ______________________ Facility MDL: ______________________

Primary Insurance: __________________ Secondary Insurance: __________________

Brief description of Complaint/Grievance : ______________________________

______________________________________________________________

Who reported the complaint/grievance? ( ) Employee ( ) Patient/Caregiver ( ) Physician ( ) Referral ( ) Regulatory Agent ( ) Manager

Who was notified about grievance/complaint? ( ) Supervisor ( ) RN ( ) Patient ( ) Caregiver ( ) MD ( ) Management ( ) Other: ______________________

Client notified of receipt on: ____________ Written report of investigation sent: ____________

State what happened:

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

State recommendations given and action plan taken:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

State what follow-up was/will be done:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Name of person completing form (Print): ______________________________ Date: ____________

Signature: ____________________________________________________ Date: ____________

Signature of department head (VP): __________________________________ Date: ____________

Signature of PI Coordinator: ________________________________________ Date: ____________

Addressed the complaint within 5 business days sign/date: ________________________________

Letter sent within 14 business days sign/date: ____________________________________________