WellsBrooke
CERTIFIED HOME HEALTH CARE

Patient Complaint Form

☐ Additional Notes/Documents Attached

Date Complaint Received: _____ **Time Received:** _____

Report Initiated By:_____

Patient Name:_____ **Date of Incident** (if appropriate):_____

MR#_____ DOB:_____ HMO/Ins:_____ Phone:_____

Name of Individual Initiating Complaint: _____

Relationship to the Patient:_____ Phone:_____

Nature of Complaint: Department:_____ Caregiver:_____

Comments: _____

_____

_____

Investigation Findings: Patient contacted on _____ (date) at _____ (time)

Comments: _____

_____

_____

DON Signature:_____ **Date:**_____

Corrective Actions: Initiated on _____ (date) at _____ (time)

Comments: _____

_____

_____

Resolution: Patient notified of resolution on _____ (date) at _____ (time)

Comments: _____

_____

_____

Name of Individual Initiating Resolution: _____

Patient satisfied with resolution? ☐ Yes ☐ No

Patient/Family notified of their right to appeal if unsatisfied? ☐ Yes ☐ No

WellsBrooke Representative Signature:_____

Title:_____ **Date:**_____