ELBOWOODS MEMORIAL HEALTH CENTER COMPLAINT FORM

Date of Incident: **Time:** **Outcome:**

Department: _____ Date of Incident: _____
Patient Involved: _____ Time: _____
Address: _____ Date of Birth: _____
_____ Chart: _____
Contact Phone Number:_____ Cell#: _____
Describe Incident/Problem:

_____
_____
_____
_____
_____

Please use the back page if you run out of room. (This will not be part of your Patient Medical Record)
Implied consent for complaints to be investigated and addressed for review

Signature of person submitting Report: _____ Date: _____

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Return To: Quality Care Director, Elbowoods Memorial Health Center
1251 Elbowoods Loop, New Town North Dakota 58763 Phone 701-627-4750

FOR OFFICAL USE

Received Date: _____ Received By: _____
Date if letter sent to Patient: _____ Routed By: _____
Routed To Dept: _____ Due Date: _____
Investigation:

_____
_____
_____

Action Taken: _____

_____
_____
_____

Department Director (If necessary):_____ Date:_____

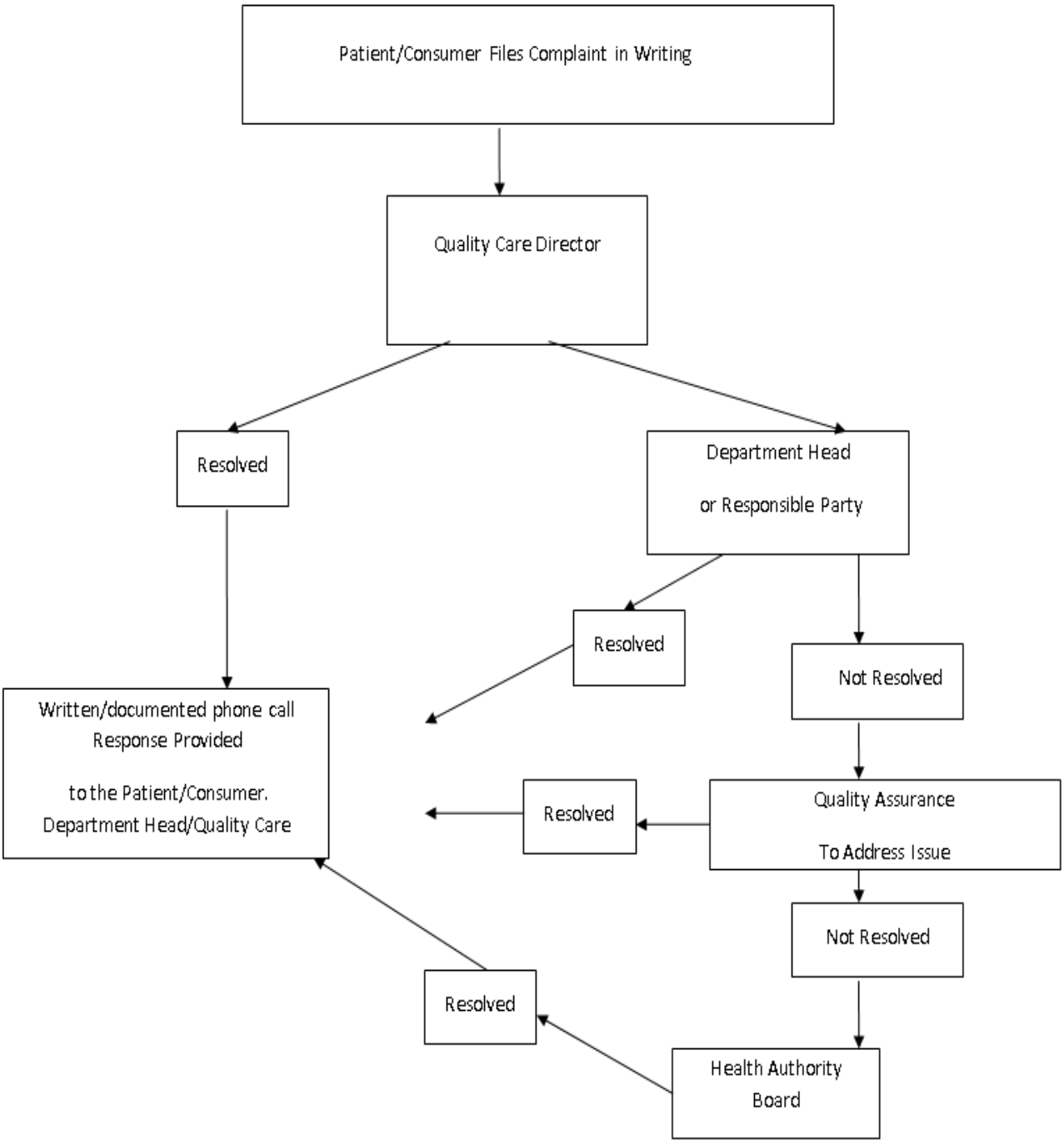
Quality Care Director:_____ Date:_____

Quality Care Specialist:_____ Date:_____

Chief Medical Officer :_____ Date:_____
Chief Executive Officer :_____ Date:_____

Dev.1999
Revised 2024

FORMAL COMPLAINT



Patient Complaint/Concern

(This will not be considered part of your patient medical record)

Created MNT 2009
Revisions 2009
Reviewed August 16, 2024