Patient Complaint Record Form Sample

Instructions: Please complete this form to record details of a patient complaint. All fields are required unless otherwise stated.

Patient Name	
Date of Birth	
Medical Record Number	
Contact Information	Phone: Email:
Date of Incident	
Time of Incident	
Location/Department	
Staff Members Involved	

Complaint Description

Describe the details of the complaint (what happened, who was involved, etc.):

Action Taken / Follow-Up

Record immediate actions taken and proposed follow-up:

Complaint Received By	
Date Received	
Signature	

Submit

The **patient complaint record form sample** is an essential document used to accurately capture and address patient concerns in healthcare settings. It facilitates organized documentation and helps healthcare providers improve service quality. Utilizing this form ensures timely resolution of complaints and enhances patient satisfaction.