



Patient Concern Report

FOR INTERNAL USE ONLY
 Scanned Filed Recorded

Name:	Date of Incident:
Provider Name:	Location of Incident:
Incident Type: <input type="checkbox"/> Provider Complaint <input type="checkbox"/> Treatment Error <input type="checkbox"/> Facilities <input type="checkbox"/> Injury <input type="checkbox"/> Other: _____	
Please write a brief statement regarding your concern.	
Signature:	Date:

For Internal Use Only		
Date Received:	Accepted by (Employee Name):	Patient Number:
Submit completed original form to the Clinical Director		

For Administrative Use Only		
Date reviewed by QI Team:		
Further action required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Further action routed to: <input type="checkbox"/> Admin/CEO <input type="checkbox"/> Board of Directors <input type="checkbox"/> CMO <input type="checkbox"/> Clinical Director <input type="checkbox"/> Facilities Director <input type="checkbox"/> Human Resources Director	
Action Taken		
Action Complete date:	Clinical Director Signature:	

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