Center for Improvement
CIHQ
in Healthcare Quality

PATIENT COMPLAINT INFORMATION FORM

Please complete the following information.
Your personal information is confidential and will not be shared with the accredited organization without your consent

Contact Information:

Your name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Email Address: _____

Are you the Patient? _____ Yes _____ No

If you are not the Patient, what is your relationship to the Patient? _____

Patient Information:

Name of Patient: _____ Age: _____ Gender: _____

Accredited Organization Information:

Hospital Name: _____

Hospital Address: _____

City: _____ State: _____ Zip Code: _____

Approximate Date of Occurrence: _____ Approximate Time of Occurrence: _____

Location in Hospital (Care Unit) where incident occurred: _____

Summary of Complaint: Please describe the incident or nature of you complaint: *(attach 2nd page if requiring more room)*

Does CIHQ have permission to disclose your name/contact information when communicating with the hospital? (Yes or No) _____

Have you informed the hospital about your incident/concern? _____ Yes _____ No

Do you wish to have CIHQ notify you of the results of our investigation? _____ Yes _____ No

Signature _____ Date: _____

Please send completed form to: CIHQ, PO Box 1540, Mexia, TX 76667 – Attn: Chief Operating Officer