LINCOLN TRAIL DISTRICT HEALTH DEPARTMENT

Good Health & A Safe Environment

COMPLAINT FORM

CLIENT/PATIENT NAME/ADDRESS:
_____
_____
_____

DATE: _____
TIME: _____
COUNTY: _____
SITE: _____

Phone Number: _____

PERSON MAKING REPORT: _____
STAFF MEMBER TAKING REPORT: _____

DESCRIPTION OF COMPLAINT:_____
_____
_____
_____
_____
_____

SIGNED: _____**DATE:** _____

ACTION TAKEN:_____
_____
_____
_____
_____

ACTION TAKEN BY: _____**DATE**_____

FOLLOW UP/REFERRAL:
_____
_____
_____
_____

FURTHER REVIEW NEEDED: ____**YES** ____**NO**

1. **PATIENT/CLIENT SATISFACTION:** _____**YES** _____**NO**
2. **INCIDENT REPORT COMPLETED:** _____**YES** _____**NO**

DIRECTOR'S SIGNATURE:_____
DATE:_____

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