PATIENT COMPLAINT FORM

PATIENT INFORMATION:	
Name of Patient:	**Name of Caller (if other than Patient) and relationship to Patient:**
Patient's date of birth (mm/dd/yyyy):	**Patient contact information:**
Name of drug or Rx#:	

COMPLAINT INFORMATION:	
Complaint date:	**Complaint taken by:**

Type of Complaint (select ALL that apply):			
Incorrect Drug		**Shipping Error**	
Incorrect Strengh/Dose/Quantity		**Customer Service**	
Incorrect Patient		**Supplies**	
Incorect Label / Directions		**Expired Product**	
Billing Concern		**Accidents**	
Injury to Patient or Staff Member		**Other (please describe)**	

Complaint Details:

For Linden Care use only:	
Date Complaint was reported:	**Date Complaint was resolved:**
Date Complaint logged on the complaint log:	**Date Patient was informed of resolution:**
Name of resolver:	
Description of resolution:	
Steps taken to prevent this complaint/error in the future, if applicable:	

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