

Division of Health Service Regulation

Complaint Intake Unit

Complaint Form

If you have any questions about this form, call DHSR (toll-free) at:
1 800 624 3004

Date:

Facility/Agency Information

Facility/Agency Name:

Street Address:

City:

State:

Zip:

Resident Information

Name of Resident/Patient/Client:

D.O.B.:

Room Number:

Male

Female

Date of Admission:

Date of Discharge:

Current Location:

Complainant Information

Name:

Relationship to Resident/Patient:

Work Phone:

Home Phone:

Cell Phone:

Street Address:

City:

State:

Zip:

Email:

Other Information

How often do you visit?

Do you attend care plan meetings?

If admitted to the hospital, is the resident returning to facility?

If we cannot reach you directly, is there someone we can contact to help us reach you?

First Name:

Last Name:

Home Phone:

Work Phone:

Cell Phone:

Street Address:

City :

State:

Zip:

Email:

Description of Complaint

Please provide as much description about your complaint as possible. Please answer as many questions below as possible.
You may attach other notes to describe your complaint.

What happened? How did it happen? When did it happen? Where did it happen? Who was involved? Were there any witnesses? Has this happened before? When? How often? Was the incident reported to the staff? Who was told about this? When were they told? What did they do about it? Is anything being done to prevent it from happening again? Has the resident/patient/client experienced any negative outcome? What? How has the negative outcome affected the resident/patient/client's functioning?

Please return form to:

Division of Health Service Regulation
Complaint Intake Unit
2711 Mail Service Center
Raleigh, NC 27699