DIVERSITY HOME HEALTH GROUP

PATIENT COMPLAINT FORM

PATIENT INFORMATION

Name: ______________________________________ Male Female Date of Birth: _____/_____/_____
Address: ______________________________________ City: _______________ State:_____ Zip: __________
Telephone: ______________________ Email address: ____
Other Information: ____

COMPLAINANT INFORMATION (If Complainant is **not** the Patient)

Name: ____ (May remain anonymous)
Address: ______________________________________ City: _______________ State:_____ Zip: __________
Telephone: ______________________ Email address: ____
Relationship to Patient: _______________________________________

Complaint Occurrence Date: ______/______/______ **Complaint Report Date**: ______/______/______

Description of Complaint: Briefly describe what occurred. Please limit comments to the facts: 1) who was involved, 2) what happened, 3) where it occurred, and 4) how/why it occurred. Type or print legibly.

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Identify any witnesses to the occurrence by name (and phone number, if available)**:**

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Return the completed form by one of the following methods:

- **FAX** to 507-205-7390
- **EMAIL** to *admin@dhhgroup.org*
- **MAIL** to our Rochester office:

DIVERSITY HOME HEALTH GROUP
1027 7TH ST NW STE 204
ROCHESTER MN 55901