Quality Incident Report Form

Please tell us what happened.

Provider Information (Where did the problem occur?)

Date_____ Time_____

Name of the
Organization_____

Address_____

_____

Phone (_____)_____

Type of Organization: Hospital____ Ambulatory Care Facility_____ Home Care Organization___ Long Term Care Facility_____ Psychiatric/Behavioral Health Care Facility_____ Network, PPO, HMO_____

_____

Quality Incident (Please state your concern)

_____

_____

_____

_____

(Attach additional pages if necessary, but please limit your statement to no more than two pages)

Were concerns made known to the provider?_____

You will be notified about action taken on your complaint provided you supply the following information. Your name will be kept confidential.

Name of Person Filing the
Report_____

Relationship to Patient: Self_____Family_____Friend_____
Advocate_____Attorney_____Employee_____Government_____

Telephone:_____ e:mail address:_____

Address:_____ Fax_____

May we contact you for further information?_____

Actions Required (Office Use Only)_____
_____

Quality Analyst:_____