STATE OF NEVADA

STEVE SISOLAK
Governor

RICHARD WHITLEY, MS
Director

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Interim Administrator

DR. IHSAN AZZAM
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
4220 S. Maryland Parkway, Suite D-810, Las Vegas, NV 89119
Telephone: 702-668-3250 Fax 702-486-6520
dpbh.nv.gov

HEALTH FACILITY COMPLAINT FORM

Complainant (your information):

NAME _____

ADDRESS _____ APT _____

CITY _____

STATE _____ ZIP_____

EMAIL _____

YOUR PHONE NUMBERS: BEST TIME TO CALL: _____

_____ _____ _____
HOME CELL WORK

RELATIONSHIP TO PATIENT SELF_____FAMILY_____FRIEND_____FACILITY STAFF _____

Patient/Resident/Client Information:

NAME _____

ADDRESS _____ APT _____

CITY _____

STATE _____ ZIP_____

EMAIL _____

DATE OF BIRTH: _____ Age: _____ SEX: _____

Do you want to remain anonymous? Yes _____ No _____

(In order for this to remain confidential, Information on the Incident, Patient Name and Dates of incidents MUST still be provided for the bureau to do a thorough investigation – If confidential, you will NOT be notified of the findings of the investigation.)

Facility Information:

Type of facility:

Hospital _____ Nursing Home/Skilled Nursing Facility _____

Group Home _____ Other (Please name) _____

NAME OF 1st FACILITY _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

ADMISSION INFORMATION:

UNIT/FLOOR/ROOM # _____

Date of Admission: _____ Admitted from: (Ex: Home, Hospital, Nursing Home) _____

Currently still in facility? Yes _____ No _____

Date of Discharge: _____ Discharged to: (Ex: Home, Hospital, Rehab) _____

NAME OF 2nd FACILITY (If Applicable) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

ADMISSION INFORMATION:

UNIT/FLOOR/ROOM # _____

Date of Admission: _____ Admitted from: (Ex: Home, Hospital, Nursing Home) _____

Currently still in facility? Yes _____ No _____

Date of Discharge: _____ Discharged to: (Ex: Home, Hospital, Rehab) _____

Event Information:

DATE: _____ TIME OF DAY_____ CONCERNS ONGOING? YES _____ NO _____

PLEASE DESCRIBE WHAT HAPPENED AND HOW:

OTHERS INVOLVED *(I.E.: STAFF, VOLUNTEERS, FAMILY MEMBERS, OTHER PATIENTS OR RESIDENTS, VISITORS - IF R.N., P.T., R.T., OR C.N.A. PLEASE ADVISE)*

NAME _____ TITLE_____ PHONE _____

NAME _____ TITLE_____ PHONE _____

NAME _____ TITLE_____ PHONE _____

WITNESSES *(CAN BE OTHER STAFF, VOLUNTEERS, FAMILY MEMBERS, OTHER PATIENTS/RESIDENTS/VISITORS)*

NAME _____ TITLE_____ PHONE _____

NAME _____ TITLE_____ PHONE _____

NAME _____ TITLE_____ PHONE _____

DID YOU SPEAK TO ANYONE ABOUT THE PROBLEM?

OMBUDSMAN _____ CHARGE NURSE_____ DIRECTOR OF NURSING (DON) _____

SOCIAL WORKER_____ MANAGER_____ CEO_____ ADMINISTRATOR _____

MEDICAL DIRECTOR_____ OTHER STAFF_____ ANY OTHER _____

LAW ENFORCEMENT _____If yes, please provide the following:

CITY_____ CASE/REPORT # _____

HAVE YOU TAKEN ANY OTHER ACTIONS? YES _____ NO _____

If so, what action was taken?

HAS ANYONE AT THE FACILITY TRIED TO ADDRESS THE SITUATION? YES_____NO _____

HOW?

Are you aware if this has happened before to the same individual, or to others? YES_____ NO _____

DETAILS:

Any Other Pertinent Information:

I WISH TO SUBMIT THIS COMPLAINT FOR REVIEW AND REQUEST THAT I BE NOTIFIED AT THE CONCLUSION OF THE INVESTIGATION REGARDING THE DISPOSITION OF THIS COMPLAINT.

SIGNED:_____ EMAIL_____DATE: _____

This form cannot be e-mailed, please save, print and:

MAIL TO: **OR** **FAX TO:**

THE DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
4220 SO. MARYLAND PARKWAY,
SUITE D-810
LAS VEGAS, NV 89119

FAX #: 702-486-6520