BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

CODY L. PHINNEY, MPH
Administrator

TRACEY D. GREEN, MD
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

COMPLAINT FORM

GENERAL INFORMATION

Complainant

NAME ____

ADDRESS ____

APT ____

CITY ____

STATE ____________________ ZIP _________________

EMAIL ____

Patient/Resident/Client

NAME ____

ADDRESS ____

APT ____

CITY ____

STATE ____________________ ZIP _______________

DOB ___________________

RELATIONSHIP TO PATIENT SELF __________ FAMILY __________ FRIEND __________ FACILITY STAFF ___________

YOUR PHONE NUMBERS

____________________ HOME

____________________ CELL

____________________ WORK

FACILITY INFORMATION

GROUP CARE ___ / SKILLED NURSING ___ / HOSPITAL ___ / OTHER ___

FACILITY INFORMATION

NAME OF 1ST FACILITY________________________________

ADDRESS ________________________________

CITY ________________________________

UNIT/FLOOR/ROOM # ____________________

PHONE _______________________________

STATE ____________ ZIP ____________

DISCHARGE DATE ________________________

NAME OF 2ND FACILITY ________________________________ ADMITTED ON ____/____/____

ADDRESS ________________________________ FROM __________________________

________________________________ DISCHARGED ON _____/_____/_______

CITY ________________________________ TO ____________________________

STATE _______________ ZIP _____________

ROOM/HALL _____________ (IF KNOWN) DOB ____________________________

PHONE ____________________________ _____/_____/_____

IS THE PATIENT/RESIDENT/CLIENT STILL IN THE FACILITY? YES _____ NO _____

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.)

INCIDENT

DATE _____________ TIME OF DAY __________ CONCERNS ONGOING? YES ____ NO ____

PLEASE DESCRIBE WHAT AND HOW THE INCIDENT HAPPENED

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 (AGE 60+ ONLY) _____ CHARGE NURSE _____ DIRECTOR OF NURSING (DON) _____

SOCIAL WORKER _____ MANAGER _____ CEO _____ ADMINISTRATOR _____

MEDICAL DIRECTOR _____ OTHER STAFF _____ LAW ENFORCEMENT _____

CITY ________________________ CASE/REPORT # ___________________________

HAVE YOU TAKEN ANY ACTIONS? YES _____ NO _____
WHAT WAS DONE

HAS ANYONE AT THE FACILITY TRIED TO ADDRESS THE SITUATION? YES _____ NO _____

HOW?

HAS THIS HAPPENED BEFORE TO THE SAME INDIVIDUAL, OR TO OTHERS? YES _____ NO _____

DETAILS *(IF YOU KNOW THEM)*

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 emailed, please save and print.

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

THE DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
727 FAIRVIEW DRIVE, SUITE E
CARSON CITY, NV 89701

FAX # : 775-684-1073