

UMDNJ-THE UNIVERSITY HOSPITAL

Allegation/Complaint Tracking Form

Patient's Name/Visitor's Name: _____

Location: _____

Internal/External Telephone #: _____

Date of Complaint: _____ Time: _____

Type of Complaint:	Customer Service	<input type="checkbox"/>	HIPPA Related	<input type="checkbox"/>
	Clinical Care	<input type="checkbox"/>	Corporate Compliance	<input type="checkbox"/>

Clinical /Service/Location: _____
 Attending Physician: _____
 Nurse Manager: _____

(Choose One)
 • In-patient _____
 • Out-patient _____
 • Private Practice _____

EVENT OCCURRED: DAY AND DATE :

TIME OF DAY:

Allegation/Visitor's Complaint:

Follow-up Actions:

Corrective Action Plan: YES NO

Resolutions:

Name/Signature of Responder:
Date:

To be completed by Patient Advocacy Department

Internal log#:	Date Received in PA:
Regulatory Visit:	Date Case Completed:
Agency:	Reported to:
Disposition:	

HIPAA/Corporate Compliance	<input type="checkbox"/>
Risk & Claims	<input type="checkbox"/>
Public Safety	<input type="checkbox"/>
Quality Improvement	<input type="checkbox"/>

Allegation/Complaint 1

Complaint Code _____
Location/Unit _____
Department _____

Validated

Not Validated

Informational

Physician Name _____

Forwarded To: _____
Date: _____
Reply Received Date: _____

Allegation/Complaint 2

Complaint Code _____
Location/Unit _____
Department _____

Validated

Not Validated

Informational

Physician Name _____

Forwarded To: _____
Date: _____
Reply Received Date: _____

Allegation/Complaint 3

Complaint Code _____
Location/Unit _____
Department _____

Validated

Not Validated

Informational

Physician Name _____

Forwarded To: _____
Date: _____
Reply Received Date: _____
