TENNESSEE DEPARTMENT OF HEALTH

COMPLAINT/INVESTIGATION INTAKE REPORT
DIVISION OF HEALTH CARE FACILITIES

Facility: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Allegation/Complaint: **(Check all that apply)**

1.	Patient/Resident Abuse	_____	10.	Proficiency Testing (Nurse Aide)	_____
2.	Patient/Resident Neglect	_____	11.	Falsification of Records/Reports	_____
3.	Patient/Resident Rights	_____	12.	Unqualified Personnel/Staff	_____
4.	Refuse Emergency Care	_____	13.	Specimen Handling	_____
5.	Environment (Living)	_____	14.	Wrong Diagnosis/	
6.	Care or Services	_____		Errors in Test Results	_____
7.	Dietary/Food Services	_____	15.	Fraud/False Billing	_____
8.	Misuse of Funds/Property	_____	16.	Death/Transfusion Death	_____
9.	Unqualified Nurse Aide	_____	17.	Other (Specify)	_____

Summary of Allegation/Complaint:

_____

_____

_____

_____

_____

_____

Person Completing Report: _____

Home Address: _____ Home Phone: _____

City: _____ Best Time to Contact: _____

State: _____ Zip: _____ email address: _____ Date/Time Report Completed: _____

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