Louisiana Health Care Practitioners, LLC

PATIENT COMPLAINT REPORT FORM

Patient Name:_____Telephone #:_____

Address: _____

Person Reporting: _____

If other than patient above:

Relationship to patient: _____Telephone #:_____

Address: _____

Date Received: _____ Time Received:_____ Received By_____

Report Received: _____In Person _____ Telephone _____ Mail (please attach)

Specifics of Report:

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Louisiana Health Care Practitioners, LLC

Summary of investigation:

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Response

Respondent: _____ Date: _____ Time:_____

Method of Response: _____In Person _____ Telephone _____Mail

Detail of Response: (Attach if Written)

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