PATIENT COMPLAINT FORM

QuickCare
COMPREHENSIVE PHARMACEUTICAL SERVICES

PATIENT INFORMATION

Name of Patient:

Name of Caller (if other than Patient) and relationship to Patient:

Patient date of birth (mm/dd/yyyy):

Patient contact information:

Name of drug or Rx#:

COMPLAINT INFORMATION

Complaint date:

Complaint taken by:

TYPE OF COMPLAINT (SELECT ALL THAT APPLY)

Incorrect Drug		Incorrect Strength	
Incorrect Dose		Incorrect Quantity	
Incorrect Patient		Incorrect Directions	
Incorrect Label		Shipping Error	
Customer Service		Supplies	
Expired Product		Billing Concern	
Accidents		Injury to Patient or Staff Member	
Other (please describe)			

COMPLAINT DETAILS

FOR QUICK CARE USE ONLY

Date Complaint was reported:

Date Complaint was resolved:

Date Complaint was logged on complaint log:

Date Patient was informed of resolution:

Name of Resolver:

Description of resolution:

Steps taken to prevent this complaint / error in the future, if applicable: