ConnextCare™
A Community of Care

Patient Complaint Form

Patient Name _____ Date of Report _____

Name and Relationship of Person Reporting (if not patient) _____

Patient's DOB _____ Contact Number for Reporter_____

Incident Details

Date of Incident _____ Location of Incident _____

Please describe what happened. Be as detailed as possible (time, names, etc.)

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Did the staff try to correct actions? ☐ Yes – please describe actions below ☐ No

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Please return this form to the nearest staff member so your concern may be brought to the Director of Quality and Safety.

If returning by mail, please send to:

ConnextCare
ATTN: Director of Quality and Safety
61 Delano Street
Pulaski, NY 13412

Thank you for taking the time to submit your concerns, we are invested in providing all patients with the highest quality of care that we can. Someone from our team will be reaching out to you shortly.