

RECORD OF CONCERN

Facility: _____ Ombudsman: _____

Date Rec'd _____

Resident Name _____ Complainant Name: _____
(or general facility)

Relationship of complainant to resident:

Resident _____ Relative/ friend _____ Ombudsman _____
 Legal guardian _____ Facility Administrator _____ Medical staff _____
 Social Services _____ Other Facility Staff _____ Anonymous _____
 Other _____

Consent of resident to work on issue: Yes No Use their name? Yes No

Complaint Category #: _____ Verified _____ Not Verified _____

Statistical Data: (Check appropriate boxes)

Black	Hispanic	Asian	Indian	Caucasian	Medicaid: Yes	No
Male	Female	Under 60	60 - 64	65 - 74	75 - 84	85 - 94
						95+

Narrative (include people spoken to and dates): _____

continue on back, if needed.

PROGRAM DIRECTOR USE ONLY:

Initial Contact Type: Phone Mail Office Visit

Consent: Verbal Written **Date Closed:** _____

Disposition:
 Resolved _____ Partially Resolved _____ Not Resolved _____ Withdrawn _____
 No Action Needed _____ Referred, final disposition not obtained _____
 Referred, agency failed to act _____ Gov't policy or regulatory change needed _____

If Referred: Agency: _____ **Date Referred:** _____

