

Patient Complaint Form for Reporting Problems

Date: _____

Patient Name: _____ Date of Birth: _____

Phone Number for Callback: _____

Can we leave a voicemail message at the phone number listed above? Select yes or no below.

Yes No

Caregiver Name (if applicable): _____

What happened? In the space below, give us all the details you have including people involved if you have names, date of incident, and the medication. Please use additional pages as necessary.

For the quickest response, call us at 1-855-312-4193.

Mail this complete form to our mailing address or fax to (504) 842-6931. You can also email the information to specialtypharmacy@ochsner.org. Complaints received through this process will be reviewed and acknowledged within 5 business days. A complaint may take up to 7 business days from the time received for resolution.

For Office Use Only:

Date Received & Acknowledged: _____

Date Resolved: _____