Oneida Comprehensive Health Division
Oneida Community Health Center
Behavioral Health Services
Anna John Resident Centered Care Community
Employee Health Nursing

Client Concern Form

Today's date	Client name	D.O.B
Telephone #	Date of Occurrence	Med Rec#
Department Staff member involved (if applicable)		
Details:		
Client Signature (if applicable)N/A		
Signature of Staff Member Receiving Concern:		
Date Received:	Time Received:	

For Administration Only

Investigation Details (date, time, objective details of incident by involved employee, etc.)	
Resolution (date, time, details, etc.)	
Notification of client or client's representative (name, date, time, etc.)	
Client or Client's Representative's Response:	
Supervisor Signature	Date

Forward to:
Health Division Quality Improvement Coordinator
Oneida Community Health Center