



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

DAVID L. LAKEY, M.D.
COMMISSIONER

MAIL OR FAX COMPLETED FORM TO:

Complaint tracking #: _____
(DO NOT FILL IN, State office use only)

PAULA MOORE, ADMIN. ASST. IV
PQCU-MC 1979
TX DEPT OF STATE HEALTH SERVICES
PO BOX 149347
AUSTIN, TEXAS 78714-9347
FAX: 512/834-6653

COMPLAINT FORM
PATIENT QUALITY CARE UNIT
REGULATORY SERVICES DIVISION

Name of person making complaint _____
(If complainant/patient is two separate people and complainant wishes to be anonymous, please write anonymous in name section; **patient name required**)
(If complainant/patient is the same and you wish to be anonymous, write anonymous in both name sections)

Mailing address of person making complaint (**not required if anonymous**) _____

City, State, Zip of person making complaint (**not required if anonymous**) _____

Phone number(s) of person making complaint (**not required if anonymous**) _____

E-Mail Address _____

Relationship to patient(s) (**not required if anonymous**) _____

Name, d/o/b and SS number (optional) of patient(s) (**not required if complainant/patient is anonymous**)

Name of facility (**required**) _____

Physical address of facility _____

City, State, Zip of facility _____

Date of admittance _____

Date of incident _____

ATTACH ADDITIONAL SHEETS IF NECESSARY

Upon receipt, your complaint will be entered into our tracking system and given a number. You will be sent a letter informing you of this number as well as a contact persons name and phone number should you wish to inquire as to the status of your complaint.