

Long-Term Care Ombudsman Case Record

CONFIDENTIAL

Ombudsman		Reference Title for the Case	
Intake Date		First Action Date	Closed Date
Intake Summary			
Anonymity Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Consent Obtained to Work on Resident's Behalf <input type="checkbox"/> Yes <input type="checkbox"/> No		Consent to Review Records <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> oral or <input type="checkbox"/> written	

Complainant

Complainant Role		Complainant Name	
Agency/Company		Address	
Home Area Code and Telephone No.		Work Area Code and Telephone No.	
Cellular Area Code and Telephone No.	Fax Area Code and Telephone No.	E-mail Address	

Facility

Type <input type="checkbox"/> NF <input type="checkbox"/> ALF	Name
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Resident

Resident Name		
Legally Authorized Representative? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name	Type of Authority <input type="checkbox"/> Legal Guardian <input type="checkbox"/> DPoA <input type="checkbox"/> MPoA

Complaints

Code (1 – 132)	Notes (describe the problem)	Verified?	Disposition
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Actions (Journal)

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