



PATIENT COMPLAINT FORM

Patient Details

Name _____

Date of birth _____

Telephone number _____

Address _____

Details of Person Making the Complaint *(If you are not patient)*

Name _____

Date of birth _____

Telephone number _____

Address _____

I authorize the complaint made on my behalf by the person above and I agree that the Axis Neuromonitoring may disclose to them (only in so far as is necessary to answer the complaint) confidential information about me which I provided to them.

Patients Signature

Date

Signature of Person Making Complaint

Date

Details of Complaint in Box Below:

[Empty box for complaint details]

Please send to:

Thomas Crosier

Vice President of Technical Operations

thomas@axisneuro.com

or by fax: 1.888.694.2947