Confidential Patient Complaint Form

All patient complaints are confidential. This report and any attachments are part of Partnership Health Center's Quality Improvement Program and therefore protected confidential documents under the law. All complaints will be given serious attention. This patient complaint form will be forwarded to the appropriate Department Manager for review and follow-up.

Patient Name: _____ DOB: _____

Address: _____

Phone: ( ) _____-_____ When is a good time to reach you: _____

Complaint received by: _____
(*Name)* *(Title)* *(Date)*

Date of complaint: _____ / _____ / _____ Time of complaint: _____

Department involved: □ Medical □ Dental □ Behavioral Health □ Reception □ Pharmacy
□ Finance □ Eligibility □ Other _____

Staff involved: _____
(Name) *(Title)*

Describe problem or reason for complaint (please print clearly):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient's signature: _____ *Date:* _____

Print name of person making complaint (if not the patient) _____

Relationship to patient: _____

Signature: _____ *Date:* _____

(If this complaint was taken via phone, please check here: ☐ *By:* _____*)*

Compliance officer: _____ *Date:* _____

**********FOR OFFICE USE ONLY**********

Route to which Department Manager:

□ Dental □ Behavioral Health □ Pharmacy □ Admin □ Facilities □ Finance
□ Medical □ Nursing □ Reception

Date received by Compliance Officer: _____ / _____ / _____ Signature: _____

Date received by Department Manager: _____ / _____ / _____ Signature: _____

Department Manager Assessment:

_____
_____
_____
_____
_____
_____

Date completed by Department Manager: _____ / _____ / _____ Signature: _____

Patient contacted: □ Letter (date mailed: _____ / _____ / _____)
□ Phone (date: _____ / _____ / _____)
□ In Person (date: _____ / _____ / _____)

CONCERN CATEGORIES:

□ **Clinical** □ **Access** □ **Repeated complaint**
□ **Personal interaction** □ **Pain management** □ **Individual with multiple complaints**

Was issue resolved? **YES** or **NO**

Describe action taken to resolve issue:

_____
_____
_____
_____

If issue was not resolved, state reason(s) why:

_____
_____
_____
_____

Dept. Manager's Signature: _____ *Date:* _____

Executive Director's Signature: _____ *Date:* _____

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