Confidential Patient Grievance or Complaint Form

Patients have the right to file a grievance regarding treatment or care that is (or fails to be) furnished or file a complaint about PHC or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner. All complaints are confidential and will be given serious attention. This patient complaint form will be routed to the appropriate Clinical Program Director and/or Department Supervisor, who will directly address your concern. For additional information, please contact the Health Director.

GENERAL INFORMATION	
Complaint received by:	
Date & Time of Complaint:	
How complaint was initially made or delivered:	□ e-mail □ in person □ phone □ in writing □ via another person: e.g., PHC Employee, TC
Name of person **making the complaint?** Relationship to the Patient? □ Self □ Other; if other, please state relationship:	
Patient Name	
Address	
Phone number(s).	
ABOUT THE COMPLAINT	
Program or Department involved	
Staff involved [include name / job title]	

SUMMARY OF PROBLEM OR REASON FOR COMPLAINT (ATTACH ADDITIONAL SHEETS OF PAPER, IF NEEDED).
Client Signature/Date:

FOR OFFICE USE ONLY

COMPLAINT TYPE	DESCRIBE ISSUE
□ **Access to Care**	• Excessive wait time in the lobby or exam room • Takes too long to get an appointment • Other:
□ **Clinical: Program Operations**	• Appointment scheduling issue • Did not receive lab/test results in a timely manner • Prescription refill issue • Referral process • Other workflow issue:
□ **Clinical: Quality of Care**	
□ **Disagrees with Purchased/Referred Care policy** □ **Disagrees with PRC Committee decision**	
□ **Facilities**	• Housekeeping issue • Patient safety or security issue • Other:
□ **Individual with Multiple Complaints** □ **Repeated or Previously Unresolved Complaint**	
□ **Pain Management Issue**	
□ **Personal Interaction with an employee/staff**	• Poor communication • Rude and/or unprofessional behavior • Other:
□ **Other**	

ROUTE TO:	
□ Administration (PHC)	□ Patient Registration
□ Behavioral Health	□ Pharmacy
□ Dental	□ Purchased/Referred Care
□ Health Education	□ Transportation
□ Medical, please specify: Medical Director, Nursing Supervisor	□ Other

FOR USE BY ADMINISTRATION:	
Was the patient complaint logged according to policy? □ Yes □ No Date: _____	Complaint Number:
Was an 'Action Letter' sent to patient? Keep a copy on file. □ Yes □ No Date: _____	Was a copy of the 'Action Letter' forwarded to the Department Supervisor for full/final resolution? □ Yes □ No Date: _____
Follow up with Dept. Supervisor to determine whether or not complaint was addressed? Date:_____Follow up by: □ Email □ Phone-□ In Person	Was a documented response by the Department Supervisor included in the Patient Complaint File? □ Yes □ No Date: _____

Describe action(s) taken by the Director or Department Supervisor to resolve issue:

Was issue resolved? □Yes □No

□ Complaint was addressed; however, not resolved to patient/client satisfaction.

If not, state reason(s) why: _____

Final follow-up phone call to patient/client?

□ Yes, by: _____

□ No, not required

FOR USE BY ADMINISTRATION
Medical Director or Designee Signature / **Date:**
Personnel or Designee Signature / **Date:**