Your Hospital's Logo Here

PATIENT RELATIONS CASE REPORT FORM

PATIENT ADVOCATE / ASSOCIATE COMPLETING FORM:	EXTENSION / BEEPER #:
COMPLAINANT:	DATE: ☐ Of Complaint ☐ Of Event
COMPLAINANT PHONE #:	DATE CASE OPENED:
COMPLAINANT ALTERNATE PHONE #:	TIME CASE OPENED:
RELATIONSHIP TO PATIENT:	DATE CASE CLOSED:

PATIENT'S NAME:

AREA(S) / ROOM(S) OF CONCERN:

NAME OF ASSOCIATE(S) INVOLVED:

ADDRESS (Optional): ☐ Complainant ☐ Patient

CITY: STATE: ZIP:

CONTACT INITIATED BY:

☐ PHONE ☐ LETTER ☐ WALK - IN

☐ REGULATORY AGENCY ☐ STAFF REFERRAL

☐ OTHER: _____

SUBJECT

☐ COMPLAINT ☐ COMPLIMENT ☐ OTHER: _____

☐ GRIEVANCE ☐ SUGGESTION _____

☐ REQUEST ☐ ASSOCIATE RECOGNITION _____

INDICATOR / TYPE OF COMPLAINT

☐ ADMISSION ☐ CARE RELATED ☐ LOSS / DAMAGED PROPERTY ☐ OTHER: _____

☐ DISCHARGE ☐ COMMUNICATION ☐ PATIENT RIGHTS / PRIVACY _____

☐ SCHEDULING ☐ ENVIRONMENTAL ☐ PHYSICIAN _____

☐ BEHAVIOR ☐ EQUIPMENT ☐ PHYSICIAN OFFICE / STAFF _____

☐ BILLING ☐ FOOD ISSUE ☐ TIMELY RESPONSE _____

NARRATIVE

PATIENT'S COMPLAINT / PERSPECTIVE:

PATIENT'S EXPECTATION(S) FOR RESOLUTION:

STAFF PERSPECTIVE / FINDINGS:

COMPLIMENT(S):

☐ **ADDITIONAL INFORMATION ON REVERSE SIDE (over, please)**

Please return completed form to PATIENT RELATIONS (Ground Floor) for Tracking / Filing

A D D I T I O N A L N O T E S (Findings / Comments / Information / Questions)

F O L L O W - U P / A C T I O N C O M P L E T E D

GRIEVANCE LETTER SENT (if applicable): ☐ 1st LETTER - Date Sent: _____ ☐ 2nd LETTER - Date Sent: _____

Other Notes Regarding GRIEVANCE LETTER:

THANK YOU for returning completed form to PATIENT RELATIONS (Ground Floor) for Tracking / Filing

PATIENT RELATIONS OFFICE: Tel # (202) 555 - 1212 Fax # (202) 555 - 1212