

Visitor and Patient Complaint Form

If a patient or visitor wishes to file a complaint to Scenic Rivers Health Services, either the patient/visitor or an employee should complete this form as accurately as possible to document the complaint, then return the signed form and any supporting documentation to their clinic.

Person Completing Report: _____ Circle: Visitor / Patient / Employee

Person Filing Complaint: _____ Date of Report: _____

Address: _____ Phone Number: _____

Complaint received by: _____

Describe the Problem or Reason for Complaint:

As a Result of Your Complaint, What Would You Like to See Happen?

I understand that staff investigating this complaint may need to see and review health records, but that all information will be kept confidential. I further understand that this complaint will in no way affect any care provided.

Patient/Visitor Signature: _____ Date: _____

Thank you for taking the time to bring your complaint to our attention.

FOR OFFICE USE ONLY

Corrective Actions Taken, including dates (as completed by Supervisor or Administration):

Patient or Visitor notified of Corrective Actions? **Y / N / NA** Date Notified: _____

How notified? (Letter, Phone, Visit, etc.): _____

Supervisor/Admin Signature: _____ Date: _____