**CONFIDENTIAL PATIENT COMPLAINT REPORT**

All patient complaints are confidential. This report and any attachments are part of One Heartt, Inc. OMHC 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, who will directly address your concerns. *If you need copies for the chart, file, etc., please copy before returning.*


# Person Making Complaint

## Name: Address:

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

Complaint received by: \_ (*Name) (Title) (Date)*

# Nature of Complaint:

## Date of Complaint: Time of Complaint:

Department Involved: Staff Involved (Name/Title):

Describe problem or reason for Complaint:

### Client’s Signature:

(*If this complaint was taken via phone, please check here*) □

### Date:

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*FOR OFFICE USE ONLY\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* Route to which Department Manager:**

|  |  |  |  |
| --- | --- | --- | --- |
| □Administration  | □Dental | □Health Education | □Pharmacy |
| □Business Office | □Facilities | □Human Resources | □Transportation |
| □Computer Support | □Finance | □Medical | □Youth & Family |
| □Contract Health Services |  | □Patient Registration |  |

Date Received by Health General Manager:

Date Action letter mailed out: \_

Signature:

Date Received by Department Manager: Signature: Followed up by: □ Letter □ Phone □ In-Person **Date of Follow Up/Final Letter mailed out**:

#### CONCERN CATEGORIES

□**Clinical** □**Access** □**Repeated Complaint** Unclear Diagnosis/disagree Length of appointment (one incident) Unclear Therapy Excessive wait time

HRC decision Prolonged date of schedule

#### □Personal Interaction □Pain Management □Individual with multiple complaints

Attitude

Unprofessional Conduct

## Was issue resolved? YES or NO

Describe action taken to resolve issue:

If not, state reason(s) why:

### Dept. Manager’s Signature: Date:

*Health General Manager’s Signature* *Date:*

**PLEASE SUBMIT COMPLETED FORM AND FINAL LETTER TO EXECUTIVE ASSISTANT**