

GOLF SURGICAL
PATIENT COMPLAINT FORM

Date Complaint Received: _____ Date Resolved: _____

Report Initiated by: _____ Referred to: _____

Patient Name _____ Date seen at GSC _____

M.R.# _____ Phone # _____

Name of Person Initiating Complaint _____

Relationship to Patient _____ Phone # _____

NATURE OF COMPLAINT: Department _____ Provider _____

- | | | |
|---------------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Scheduling | <input type="checkbox"/> Medical Care | <input type="checkbox"/> Rude Staff |
| <input type="checkbox"/> Bill/Coll. | <input type="checkbox"/> Referral | <input type="checkbox"/> Policy |
| <input type="checkbox"/> Prob. w Prov | <input type="checkbox"/> Post op Call | <input type="checkbox"/> Other |
-

INVESTIGATION: Patient Contacted: Date _____ Time _____

Manager's Signature _____

RESOLUTION: Patient Notified: Date _____ Time _____

Name of person resolving problem _____

Patient Satisfied? Yes No

Patient/Family notified of right
to appeal if unsatisfied? Yes No