|  |  |  |
| --- | --- | --- |
| **Patient/Client Information**  **\*Please write “anonymous” if you wish to remain anonymous** | | |
| **\*Patient/Client Name or MRN #:** | | **Patient/Client Phone:** |
| **Patient/Client Email:** | | **What is your preferred mode of communication:**  **□ Phone □ Email** |
| **Program Area:**  □ Behavioral Health □ Dental  □ Imaging  □ Lab  □ Optometry  □ Pediatrics  □ Pharmacy  □ Physical Therapy □ Podiatry | □ Primary Care  □ Public Health □ Patient Registration □ Scheduling  □ Walk In Clinic  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |
| --- | --- |
| **Complaint Information** | |
| Complaint Date: | Date of Visit: |
| Form Completed by: | |
| Complaint Details (Please state the details of why you are upset): | |
| How to Resolve (Please state how you would like to see this issue resolved): | |

**\*\*\*Completed forms may be placed into the white locked boxes throughout our facilities, given to the Patient Advocate staff or sent via email to** [**QM@srpmic-nsn.gov**](mailto:QM@srpmic-nsn.gov)**\*\*\***