|  |
| --- |
| **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****\*\*\***