Patient/Family Grievance

Thank you for sharing your experience. Your willingness gives us the opportunity for improvement and allows us to fulfill our mission to provide safe and quality healthcare services to those we serve in an environment based on respect, dignity and excellence. All patient complaints are confidential. This report and any attachments are part of the Madelia Health Quality Improvement Program and therefore protected confidential documents under the law. All complaints will be given serious attention.

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 concern or reason for complaint: _____

_____

_____

_____

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_____

_____

Client's Signature: _____ *Date:* _____

******************************FOR OFFICE USE ONLY**************************************

Route to which Department Manager:
□ Administration □ Quality/Risk Management □ Nursing □ Pharmacy □ Lab □ Radiology □ Physical Therapy
□ Clinic □ Home Care □ Housekeeping/Laundry □ Dietary
□ Patient Registration □ Business Office □ Facilities □ Human Resources
Date Received by CCO: _____ Signature:_____
Date Action letter mailed out:_____
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 □ NO Potential to become a claim? □ YES □ NO
Describe action taken to resolve issue:

_____

_____

_____

_____

_____

If not, state reason(s) why: _____

_____

_____

_____

Dept. Manager's Signature: _____ *Date:*_____

CCO's Signature: _____ *Date:*_____

PLEASE SUBMIT COMPLETED FORM AND FINAL LETTER TO CHIEF CLINICAL OFFICER