NEVADA HEALTH CENTERS

Patient Feedback Form

Patient Information

Patient Name: _____ Patient Date of Birth:_____

Preferred Follow-up Method (Choose One)

Phone ☐ Mail ☐ Email ☐ N/A ☐

Phone Number: _____ Email:_____

Address:_____

Name of the Person Reporting (if different from patient):

_____

Relationship to the Patient: _____

Grievance Information

Date the Incident Occurred _____

Employee/Employees Named In the Incident: _____

Clinic Location and Department of the Incident:

_____

Name of Employee Documenting Grievance: _____

Complaint Type (Check all that apply):

☐ Access	☐ Billing	☐ Breakdown in Communication	☐ Breakdown in Process
☐ Care/ Clinical Quality	☐ Confidentiality	☐ Physical Environment	☐ Interaction with Staff
☐ Wait Time/ Efficiency	☐ Cost of Care	☐ Other (be specific)	

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Brief description of the complaint:

Office Use

Summary of Investigation and Resolution:

Date Supervisor Received: _____ Supervisor Signature:_____

Date DOO Received:_____ DOO Signature: _____

Date Patient Contacted with Resolution:_____

Log Number: _____ _Date Logged:_____ Date Completed:_____