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_____

[ ] Scheduling	[ ] Medical Care	[ ] Rude Staff
[ ] Bill/Coll.	[ ] Referral	[ ] Policy
[ ] Prob. w Prov	[ ] Post op Call	[ ] 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