PATIENT GRIEVANCE REPORT

To our patients: prior to completing this form, please make every effort to communicate your concerns to the staff, supervisor and management involved. Please be assured that if you are unable to do so, your formal complaint will not affect your care or treatment. All matters will be handled in a confidential manner, and you will be contacted within 24 hours to acknowledge receipt of your Grievance. You will receive a written response regarding our findings and resolution within 7 days minimum and 30 days maximum. This is part of your Patient Rights and fully supported by the Coronado surgery Center.

DATE OF THE REPORT:_____

PATIENT NAME:_____

DATE/TIME OF THE OCCURRENCE OR CONCERN:

_____

PLACE OF THE OCCURRENCE OR CONCERN:_____

DESCRIPTION OF YOUR CONCERNS, EVENTS, INDIVIDUALS INVOLVED: (***PLEASE USE THE BACK OF THE FORM IF MORE SPACE IS REQUIRED TO FULLY OUTLINE YOUR CONCERNS)***

_____

_____

_____

_____

_____

WHICH "PATIENT RIGHT" IS OF CONCERN TO YOU?

_____

_____

_____

_____

WHAT WOULD RESOLVE THIS ISSUE FOR YOU?_____

_____

_____

_____

X_____

SIGNATURE OF PATIENT OR PERSON COMPLETING THIS REPORT (*if not signed by patient, state relationship to patient)*

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DATE INVESTIGATION INITIATED:_____
FINDINGS:_____
_____
_____
_____
_____
_____
_____

PLAN/RESOLUTION:_____
_____
_____
_____

INDIVIDUALS INVOLVED IN INVESTIGATION:_____
_____
_____
_____

Date of patient initial contact:_____
Findings/resolution sent/date:_____

Outcome:
_____
_____
_____
_____
_____

Appealed by patient? ☐ **Yes** ☐ **No (If appealed, log as separate Grievance and restart process)**

Date reported to quality/patient safety committee:_____

Date reported to Board:_____

Administrator Signature:_____

Date:_____