

FOR OFFICE USE ONLY

COMPLAINT TYPE	DESCRIBE ISSUE
<input type="checkbox"/> Access to Care	<ul style="list-style-type: none"> • Excessive wait time in the lobby or exam room • Takes too long to get an appointment • Other:
<input type="checkbox"/> Clinical: Program Operations	<ul style="list-style-type: none"> • Appointment scheduling issue • Did not receive lab/test results in a timely manner • Prescription refill issue • Referral process • Other workflow issue:
<input type="checkbox"/> Clinical: Quality of Care	
<input type="checkbox"/> Disagrees with Purchased/Referred Care policy <input type="checkbox"/> Disagrees with Resource Committee decision	
<input type="checkbox"/> Facilities	<ul style="list-style-type: none"> • Housekeeping issue • Patient safety or security issue • Other:
<input type="checkbox"/> Individual with Multiple Complaints <input type="checkbox"/> Repeated or Previously Unresolved Complaint	
<input type="checkbox"/> Pain Management Issue	
<input type="checkbox"/> Personal Interaction with an employee/staff	<ul style="list-style-type: none"> • Poor communication • Rude and/or unprofessional behavior • Other:
<input type="checkbox"/> Other	
ROUTE TO:	
<input type="checkbox"/> Administration (KTHFS)	<input type="checkbox"/> Patient Registration
<input type="checkbox"/> Behavioral Health (YFGC)	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Dental	<input type="checkbox"/> Purchased/Referred Care
<input type="checkbox"/> Health Education	<input type="checkbox"/> Transportation
<input type="checkbox"/> Medical, please specify: Medical Director, Nursing Supervisor, Clinic Office Manager	<input type="checkbox"/> Other
FOR USE BY ADMINISTRATION:	
Was the patient complaint logged according to policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Complaint Number: _____
Was an 'Action Letter' was mailed out to patient? Keep a copy on file. <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Was a copy of the 'Action Letter' forwarded to the Department Manager for full/final resolution? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
Follow up with Dept. Manager to determine whether or not complaint was addressed? Date: _____ Follow up by: <input type="checkbox"/> E-mail <input type="checkbox"/> Phone <input type="checkbox"/> In-Person	Was a documented response by the Department Manager included in the Patient Complaint File? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____

Describe action(s) taken by the Program Director or Department Manager to resolve issue:

Was issue resolved? Yes No

Complaint was addressed; however, not resolved to patient/client satisfaction.

If not, state reason(s) why: _____

Final follow-up phone call to patient/client?

Yes, by: _____

No, not required

FOR USE BY KTHFS ADMINISTRATION

Administrative Officer or Designee Signature / **Date:**

Health General Manager or Designee Signature / **Date:**