CONFIDENTIAL
PATIENT COMPLAINT REPORT

All patient complaints are confidential. This report and any attachments are part of Klamath Tribal Health & Family Services Quality Improvement Program and therefore protected confidential documents under the law. All complaints will be given serious attention. This patient complaint form will be forwarded to the appropriate Department Manager, who will directly address your concerns.

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 problem or reason for Complaint: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client's Signature:_____ *Date:* _____

(*If this complaint was taken via phone, please check here*) ☐

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

Route to which Department Manager:

□Administration (KTH&FS)	□Dental	□Health Education	□Pharmacy
□Business Office	□Facilities	□Human Resources	□Transportation
□Computer Support	□Finance	□Medical	□Youth & Family
□Contract Health Services		□Patient Registration	

Date Received by Health General Manager: _____ 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**
- Unclear Diagnosis/disagree
- Unclear Therapy
- HRC decision

☐**Access**
- Length of appointment
- Excessive wait time
- Prolonged date of schedule

☐**Repeated Complaint**
- (one incident)

☐**Personal Interaction**
- Attitude
- Unprofessional Conduct

☐**Pain Management**

☐**Individual with multiple complaints**

Was issue resolved? YES or NO

Describe action taken to resolve issue: _____

_____

_____

_____

_____

If not, state reason(s) why: _____

_____

_____

_____

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

*Health General Manager's Signature*_____ *Date:*_____

PLEASE SUBMIT COMPLETED FORM AND FINAL LETTER TO EXECUTIVE ASSISTANT

If you need copies for the chart, file, etc., please copy before returning.