Clarinda
Regional Health Center

PATIENT COMPLAINT/GRIEVANCE FORM

Every patient should have reasonable expectations of care and services to him/her while at Clarinda Regional Health Center (CRHC). CRHC is committed to addressing situations when those expectations are not met in a timely, reasonable, and consistent manner.

CRHC personnel are available to assist you with completing this form, filing a formal grievance over the phone, or to answer questions at (712) 542-2176. Please return this form to: **Clarinda Regional Health Center, ATTN: Quality Manager, PO Box 217, Clarinda, IA 51632** or bring to CRHC's Admissions Check-in Counter in the main lobby.

NAME OF PATIENT:

Name of Person Completing Form (if different from patient–Please Print): _____

Patient Name(print): _____ Date: _____
(Last) (First) (M I)

Address: _____
(Street) (City) (St) (Zip)

Telephone: _____ Date of Birth (MM/DD/YYYY): _____ Medical Record #: _____
(Optional)

NATURE OF COMPLAINT:

☐ *HIPAA Violation* ☐ *Quality of Care* ☐ *Billing* ☐ *Customer Service* (including appt scheduling or wait times)

COMPLAINT INVOLVES (MAY CHOOSE MORE THAN ONE):

☐ *Dr. Clinic* ☐ *Specialty Clinic* ☐ *Nursing* ☐ *Dietary* ☐ *Respiratory* ☐ *Lab* ☐ *Rehab* ☐ *Radiology* ☐ *Social Srvcs*

☐ *Surgery* ☐ *Medical Records* ☐ *Emergency Dept.* ☐ *Billing* ☐ *Administration* ☐ *EMS/Ambulance* ☐ *Other:*_____

DESCRIPTION OF COMPLAINT:

(Please be as specific as possible with the following: (1) state your concern; (2) date of event; (3) time of event; (4) staff member(s) involved; (5) location of event. Attached a 2nd sheet if you need more space to write.)

BACK PAGE TO BE COMPLETED BY CRHC STAFF

These steps to be followed from receipt of grievance/complaint thru resolution.

- ☐ Patient/Patient Representative/CRHC Primary Contact completes the form. ("Primary contact" is defined as CRHC employee responsible for investigating and completing form; Not necessarily the first person hearing/receiving the grievance/complaint.)
- ☐ If a patient or patient's representative completes the form and delivers to any CRHC employee, that employee is to make one copy and deliver the original form to the respective department manager and the copy to the Quality Manager.
- ☐ Respective Department Manager initiates an investigation into the grievance/complaint. Quality Manager logs the grievance/complaint into the log.
- ☐ An investigation must be initiated as soon as reasonably possible with the goal of identifying any issues and resolution within 5 business days. Results of the investigation - identified resolution or action taken - shall be reported on the original form (in section below) and delivered to the Quality Manager within 5 business days of receipt of the initial report.
- ☐ Quality Manager shall provide a written letter within 7 business days to the patient or patient's representatives acknowledging receipt of the original grievance/complaint and conveying via the same letter any action taken to resolve the issue as a result of the complaint.

THIS SECTION TO BE COMPLETED BY THE DEPARTMENT MANAGER/REVIEWER:

Name of CRHC Employee Reviewing Complaint: _____

Date Initial Complaint Received by Reviewer: _____

Date Report Completed by Reviewer: _____

Reviewer Comments/Resolution:

Action Taken to Resolve:

QUALITY MANAGER SECTION

Date Form was Received by Quality Manager: _____

Date Initial Letter Mailed to Patient: _____

Quality Manager Initials Upon Completion: _____

Date of Final Resolution if Different from Mail Date: _____