

COMMENT FORM



Reason for Filling in Form:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Concern | <input type="checkbox"/> Congratulations |
| <input type="checkbox"/> Complaint | <input type="checkbox"/> Recommendation |

Date received: _____ Occurrence date: _____
Patient's name: _____ Department/Room Number: _____
Home address: _____ Telephone: Residence: _____
Work: _____

Letter from Patient/Family attached? Yes No

Relationship to the Patient: Self Spouse Child Parent Friend
Other _____

Are you the legal decision maker? Yes No

(Verbal/written consent is required if the form is filled out on behalf of someone else and you are not the legal decision maker.)

Name of staff member/area you want to comment on: _____

I want to address:

- | | |
|--|---|
| <input type="checkbox"/> Communication Style | <input type="checkbox"/> Management of Patient Care |
| <input type="checkbox"/> Health Records or Report Completion | <input type="checkbox"/> Availability of Staff |
| <input type="checkbox"/> Staff Courtesy | <input type="checkbox"/> Interdisciplinary Issues |
| <input type="checkbox"/> Finding Your Way | <input type="checkbox"/> Noise Level |
| <input type="checkbox"/> Financial/Billing | <input type="checkbox"/> Confidentiality |
| <input type="checkbox"/> Office Cleanliness | <input type="checkbox"/> Other _____ |

Please explain the experience or event you would like to share:

Signature/Title/Department: Patient Visitor Staff

