PATIENT GRIEVANCE FORM

If you are requesting assistance in resolving a problem with this organization, please fill out the sections that relate to your concern(s). Return the form to the receptionist or to the following address:

The Center for Men's and Women's Urology, LLC
24076 SE Stark, Suite 310
Gresham, OR 97030
503 492-6510

Patient Name:_____
Address:_____
City:_____State:_____
Daytime Phone: ( ) _____Date of Birth_____

May we leave a message for you on the telephone answering machine? ❒yes ❒no

Grievance Involves: (check (✓) the one that applies)

❒ Organizational staff
Name:_____Title:_____
Name:_____Title:_____

❒ Treatment Related/Quality of Care
Briefly specify:_____
_____

❒ Other (specify)_____
_____
_____
_____

❒ I choose to remain anonymous. I understand by remaining anonymous this may result the inability to fully process my grievance.

❒ I choose to represent myself during this grievance process.

❒ I have chosen a representative to help me during this grievance process.
Please list the name and relationship if any of the representative:_____
_____

_____ _____
Signature of Patient/Person Filing Grievance Date

_____ _____
Signature of Patient Representative Filing Grievance Date

Describe your grievance in Detail:
List dates and approximate times when incident or action occurred. Please remember to restrict your comments to the facts associated with this grievance. Attach additional sheets if necessary.

Reviewed by:_____ Title:_____
Reported to the Medical Director on: _____