OHSU PATIENT RELATIONS

Patient feedback form

Patient name (please print):_____ Date of birth:_____

Address:_____

Phone:_____ Cell:_____

Submitted by:_____ Medical record no. (if known): _____

This concern is regarding my bill: ❑ Yes ❑ No

This concern is regarding my patient care: ❑ Yes ❑ No

1. Did you discuss this concern with a member of your health care team? ❑ Yes ❑ No

2. Please write a brief statement:

Who was involved: _____

When did the issue occur: _____

Where did the issue occur: _____

What happened? _____

_____

_____

_____

_____

(Use back of form if necessary and/or attach related documents)

I authorize the OHSU Patient Advocate to review the above concern and advocate on my behalf. I understand the advocate will review my medical record and/or discuss my case with my OHSU health care provider(s).

_____ _____

Signature of patient or guardian Date

Return to: OHSU Patient Relations Dept. UHS-3, 3181 S.W. Sam Jackson Park Rd., Portland, OR 97239
503-494-7959 Fax: 503-494-3495 E-mail: advocate@ohsu.edu www.ohsu.edu/advocate

If we still have not addressed your concern, the following resources are also available to assist you:

- Oregon Health Authority, Health Care Regulation and Quality Improvement: 971-673-0540
- State Quality Improvement Org., Acumentra Health: 503-279-0100
- DNV-GL Healthcare: 866-496-9647
- The Joint Commission: www.jointcommission.org/report_a_complaint.aspx

Confidential: In accordance with ORS 41.675 ***July 2019***

OHSU