PATIENT FEEDBACK FORM

Patient Name (please print):_____Date of birth:_____

Address:_____

Phone Number:_____Cell Number:_____

Submitted by _____Medical Record # (if known)_____

This concern is regarding my statement: ☐ SI ☐ NO

This concern is regarding my patient care: ☐ SI ☐ NO

1. Did you discuss this with a member of your healthcare team? ☐ SI ☐ 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 Norwalk Community Health Center to review the above concern and advocate on my behalf. I understand that my medical record will be reviewed and/or my case will be discussed with my NCHC healthcare providers.

_____ _____

NORWALK Community HEALTH CENTER
Care Within Reach

Signature of Patient or Guardian Date