

***PATIENT RELATIONS:
COMPLIMENTS AND CONCERNS***

Feedback Form

Date Feedback Provided: _____

Feedback Given by: Patient Visitor

First Name **Last Name** **Room or Phone Number**

Type of Feedback:

Compliment
Suggestion
Complaint

Topic:

Patient Care
Safety
Food

Cleanliness
Other
Specify:

Your Feedback

(To help us best direct your compliment/concern, please be as specific as possible.)

Have you reported/suggested this to a staff member? Yes No **Date:** _____

If yes, to whom was it reported/suggested?

First Name **Last Name** **Department/Profession**

THANK YOU FOR YOUR FEEDBACK

Please drop off at Main Reception, 1st Floor. To be forwarded to Patient Relations.
If this is a concern, you can expect to be contacted for follow up within 2 business days.
Please be aware that anonymous complaints will not be investigated.