SERVICE RECOVERY FORM Date: __________

PATIENT NAME____

MRN#_______________________DOB_____________

IN-PATIENT _____ OUT-PATIENT _____ DATE OF INCIDENT_________________

PERSON MAKING COMPLAINT & RELATIONSHIP; IF NOT PATIENT:

____

CONTACT INFORMATION: ____

METHOD OF RECEIPT:

IN PERSON______ _PHONE______ LETTER____ OTHER **(SPECIFY)** ______________

DEPARTMENT & LOCATION OF INCIDENT/COMPLAINT

____

DESCRIBE COMPLAINT: (Attach letter if appropriate) ______________________

____

____

____

____

YOUR FOLLOW-UP: ____

____

____

____

WAS PATIENT SATISFIED? YES___ NO____

FURTHER FOLLOW UP REQUIRED? YES___ NO____

SUBMITTED BY (Print): ____________________________________
DATE:_____________________ CONTACT#________________

BRING COMPLETED FORM TO ROOM C242 or FAX (2-7929) or SCAN & EMAIL WITHIN 24 HOURS OF COMPLAINT