PATIENT GRIEVANCE FORM

All information will be kept confidential. Complete all blanks that relate to your concern.
Return form to Quality Insights Renal Network 3(see address below).

NAME: ____

ADDRESS: ____

____

DAYTIME PHONE #: ___________________________

IF PHONE UNAVAILABLE, CAN WE LEAVE A MESSAGE FOR YOU AT YOUR DIALYSIS FACILITY? O YES O NO

FACILITY/UNIT ASSOCIATED WITH THE GRIEVANCE:

NAME: ____

ADDRESS: ____

____

DIALYSIS SCHEDULE ____________________________________

GRIEVANCE INVOLVES (Check all specifically involved):

O **Facility/Unit Staff**

Name: ________________________ **Title:** __________________________

Name: ________________________ **Title:** __________________________

O **Physician(s)**

Name: ____________________________________

Name: ____________________________________

O **Other (specify)**

____

____

Quality Insights Renal Network 3 · 109 South Main Street, Suite 21 · Cranbury, NJ 08512
Phone: 888-877-8400 · Fax: 609-490-0835

DESCRIBE YOUR CONCERN OR 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.

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Please check the ONE that applies to you:

O I have approached the facility with this grievance and am not satisfied with the outcome or handling. I am not satisfied because (specify reason):

____

____

O I have not approached the facility with this grievance because (specify reason):

____

____

Please check ONE:

O I choose to represent myself during this grievance process.

O I have chosen a representative to help me during this grievance process.

Name: ____

Address: ____

____

Daytime Phone #: ________________________________

Please check ONE:

O I allow the Network to release my identity to the appropriate individuals in the processing of this grievance.

O I wish to remain anonymous. I understand that remaining anonymous may result in the inability to fully process my grievance. I will be notified by the Network if this is the case.

____ ______________

Signature of Person Filing Grievance Date

____ ______________

Signature of Patient Representative (if applicable) Date