**OHSU PATIENT RELATIONS**

# Patient Feedback Form

OREGON HEALTH & SCIENCE UNIVERSITY

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
Telephone: 503 494-7959 | Fax: 503 494-3495 | www.ohsu.edu/advocate

**If we still have not addressed your concern, the following resources are also available to assist you:**
State of Oregon, Health Care Licensure and Certification Section: 971 673-2700
State Quality Improvement Organization, Acumentra Health: 1 800 633-4227
The Joint Commission, Office of Quality Monitoring: 1 800 994-6610 | complaint@jointcommission.org

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