THE QUEEN'S MEDICAL CENTER

PATIENT RELATIONS
1301 Punchbowl Street • Honolulu, Hawaii 96813
Phone: 547-4602 • Fax: 537-7883

CUSTOMER COMMENT FORM

Please indicate the nature of your comments:

_____ I have a **compliment** I would like to share

_____ I have a **suggestion** to offer

_____ I have a **complaint** I want to make

_____ I want to make a **statement**

It is only through your feedback that Queen's can continually evaluate and improve our services. Thank you for taking the time to share your comments with us. Should you have a complaint, any member of your health care team may assist you, including the Unit/Department manager(s). You may also contact Patient Relations at 547-4602 or mail in this form to have your complaint addressed. Your right to file a complaint will not compromise your future access to care. We will address your complaint with the Department Manager(s) and attempt to resolve your concerns and notify you of our findings within 14-30 days from the date of receiving your complaint. If you are not satisfied with the resolution in response to your complaint, you can be referred to the QMC Grievance Committee. All referrals to the QMC Grievance Committee must be submitted in writing and mailed to Patient Relations at the above address. You also have the right to access protective and advocacy agencies in the community, Patient Relations can provide you with the listing of Patient Protective Services upon request.

Instructions

1. Please detail as much information as you can in your written statement to assist us in investigating and responding back to you. If you need more space, feel free to attach a separate sheet to this form.
2. You may return this form by mail, fax, or give to any member of your health care team and ask them to forward it to Patient. If you have any questions, please call Patient Relations at 547-4602, Monday through Friday, 8am - 6pm.

Patient Name: (If applicable)	**Date of Service:**	**Department that Provided Service:**

(You may continue your written statement on back)

Describe what would be an acceptable outcome for you:

Would you like someone to contact you? YES NO **If yes**, your phone number / address:

Your NAME: **Relationship to Patient:**
Date:

FOR OFFICE USE ONLY: Name of Patient Advocate handling referral: _____

FOLLOW UP SENT TO _____ DATE: _____ NEED RESPONSE BY DATE: _____

COMMENTS: