THE QUEEN'S MEDICAL CENTER
PATIENT RELATIONS
1301 Punchbowl Street • Honolulu, Hawaii 96813
Phone: 691-4602 • FAX: 691-7883

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 you comments with us. Should you have a complaint or grievance, any member of your health care team may assist you. Your right to file a complaint or grievance will not compromise your future access to care. We will address your complaint or grievance with the Department Managers and attempt to resolve your concerns and notify you of our findings within 14-30 days from the date of receiving your written statement. If you are not satisfied with the resolution we have provided 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: QMC Grievance Committee, c/o Patient Relations, The Queen's Medical Center, 1301 Punchbowl Street, Honolulu, Hawaii, 96813.

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. If you are requesting a response, we will be in touch with you in 14-30 days from the date this form is received.
3. You may return this form by mail, fax, or give to any member of your health care team. If you have any questions, please call 808-691-4602.

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 call you? YES NO If **yes**, your phone number:
Would you like your response: ☐ **In Writing** OR ☐ **Verbally**

Your NAME: **Relationship to Patient:**
ADDRESS:

Date:

FOR OFFICE USE ONLY: Name of Patient Advocate handling referral: _____
FOLLOW UP SENT TO _____ DATE: _____ NEED RESPONSE BY DATE: _____
COMMENTS:

(Page 2) **CUSTOMER COMMENT FORM**

THANK YOU FOR YOUR COMMENTS