Quality Insights
Renal Network 4

PATIENT GRIEVANCE FORM

All information will be kept confidential. Complete all blanks that relate to your concern.

Return this completed form to Quality Insights Renal Network 4 (see address below).

NAME: _____

ADDRESS: _____

DAYTIME PHONE #: _____

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

FACILITY/UNIT ASSOCIATED WITH THE GRIEVANCE:

NAME: _____

ADDRESS: _____

_____

DIALYSIS SCHEDULE _____

GRIEVANCE INVOLVES (Check all specifically involved):

❑ Facility/Unit Staff

Name: _____ Title: _____

Name: _____ Title: _____

❑ Physician(s)

Name: _____

Name: _____

❑ Other (specify)_____

_____

Quality Insights Renal Network 4 · 610 Freedom Business Center, Suite 102 · King of Prussia, PA 19406

Phone: 800-548-9205 · Fax: 610-783-0374

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:

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

_____

_____

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

_____

_____

Please check ONE:

❑ I choose to represent myself during this grievance process.

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

Name: _____

Address: _____

_____

Daytime Phone #: _____

Please check ONE:

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

❑ 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