Quality Insights
Renal Network 5

PATIENT GRIEVANCE FORM

Completion of this form is not required.
Grievances can also be filed by contacting the Network by email or phone.
All information will be kept confidential.
Return this form to the address below.

NAME: _____

ADDRESS: _____

_____

DAYTIME PHONE #: _____

CLINIC ASSOCIATED WITH THE GRIEVANCE:

NAME: _____

ADDRESS: _____

_____

GRIEVANCE INVOLVES (Check all specifically involved):

- ❑ **Facility/Unit Staff**
  Name:_____ **Title:**_____
  Name:_____ **Title:**_____
- ❑ **Physician(s)**
  Name: _____
  Name: _____
- ❑ **Other (specify)** _____

Quality Insights Renal Network 5
PO Box 29274
Henrico, VA 23242
Phone: 804.320.0004 Fax: 804.320.5918
Email: network5@qualityinsights.org
(DO NOT EMAIL PATIENT-SPECIFIC OR PATIENT-IDENTIFYING INFORMATION)

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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 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 (PLEASE COMPLETE THE REPRESENTATIVE AUTHORIZATION FORM.)

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 and if this is the case, I will be notified by the Network.

_____ _____

Signature of Person Filing Grievance and Relationship to Patient Date

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