Lake Health District
Quality Care Close to Home

Lake District Hospital
Lake Health Clinic
Lake Health Specialty Clinic
Lake County Public Health
Lake District Emergency Medical Services

COMPLAINT/GRIEVANCE FORM

*Facility/department which this complaint/grievance is about?			*Date/Time:				AM/PM		
*What is the name, date of birth, gender, and nationality of the affected patient/client? (If more than one patient/client, list all on separate attachment.)									
*Last Name		*First Name		*Middle Init.		*Date of Birth			
*Gender	*Nationality	* Was a specific nurse, practitioner (physician or mid-level), or other staff member involved?				Yes*	*Name if known		
						No			
*Full name of person making complaint/compliment/grievance:				*Phone number (Best contact number):					
*Address:		*City:				*State	*Zip Code		
* Relationship to the patient:		Self		Family		Guardian / POA		Other Relationship (please define):	
* Email for contact (if preferred method):									
* In what department, or on what unit did the incident(s) or problem(s) occur?			* Is the patient/client still in the facility or still receiving services?				Yes		
							No		
*When did the incident occur?									
*Please describe what happened in detail. (If additional space is needed, please attach separate pieces of paper.): (*facts only please*)									
*Expectations		Apology		Better Communication		Don't want it to happen to anyone else			
		Compensation		Talk to Administration		Billing Adjustment			
		Face to Face or Notification to:							
		Other							

Lake Health District

Phone: 541-947-2114 « 700 South J Street Lakeview, OR 97630