Freeport Health Network Patient Concern Form

Date of concern: _____ Taken by: _____ Phone #: _____

Patient's name: _____ DOB: _____ DOS: _____
(Last, first, middle initial)

Location of service/department: _____ Cost center #: _____

Name of caller/relationship: _____ Acct. #/ medical rec. #: _____

Address: _____

Phone # (home): _____ (work): _____

Best time/times to call: _____

Attitude of caller: ☐ Upset ☐ Angry/loud ☐ Frustrated ☐ Calm ☐ Obnoxious

Description of concern: _____

_____

_____

_____

_____

_____

Patient/staff expectations: _____

Date concern referred: _____ Referred to: _____

**** CONCERN TO BE CLOSED IN SEVEN WORKING DAYS ****

Actions taken: _____

_____

_____

_____

_____

_____

Service recovery? ☐ Yes ☐ No

Type of service recovery: _____ Amount: _____

Date final contact made: _____

Final contact made by name & title: _____

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