PATIENT COMMENT/CONCERNS FORM

LAMPREY HEALTH CARE
Where Excellence and Caring go Hand in Hand

To be completed by Site Administrator

__Phone	__Raymond Office
__Follow-up	__Newmarket Office
__Service	__Nashua Office
__Clinical	__Access
__Waiting Time	__Billing
Other_____	

PERSON MAKING COMMENT/CONCERNS:

Name _____DOB_____

Telephone Number_____ Date _____

☐ Please indicate permission to research your complaint using information from your medical record

NATURE OF CONCERN:

Completed by: Date:

ROUTE TO PRACTICE MANAGER OR NURSE MANAGER

COMMENTS - ADD'L INFORMATION: (by appropriate involved staff)

Completed by:_____ Date:_____

FOLLOW-UP including action taken internally to address problem, if any: (by Practice Manager, Medical Director, and/or Nurse Manager)

Signature: Date:

COMMUNICATION WITH PATIENT/PERSON FILING CONCERN:

☐ Resolution with patient. (If no, please comment why).

Signature: Date: