Quality Insights
Mid-Atlantic Renal Coalition

PATIENT GRIEVANCE FORM

All information will be kept confidential. Complete all blanks that relate to your concern.
Return form to the Mid-Atlantic Renal Coalition (see 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)**

_____

_____

01/17

Mid-Atlantic Renal Coalition · 300 Arboretum Place, Suite 310 · Richmond, Virginia 23236
Phone: 804/320-0004 · Fax: 804/320-5918 · e-mail: marc@nw5.esrd.net

Quality Insights
Mid-Atlantic Renal Coalition

PATIENT GRIEVANCE FORM

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.

Mid-Atlantic Renal Coalition · 300 Arboretum Place, Suite 310 · Richmond, Virginia 23236
Phone: 804/320-0004 · Fax: 804/320-5918 · e-mail: marc@nw5.esrd.net

Quality Insights
Mid-Atlantic Renal Coalition

PATIENT GRIEVANCE FORM

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

Mid-Atlantic Renal Coalition · 300 Arboretum Place, Suite 310 · Richmond, Virginia 23236
Phone: 804/320-0004 · Fax: 804/320-5918 · e-mail: marc@nw5.esrd.net