



PATIENT ADVOCACY WORKSHEET

Patient Complaints & Grievances Template

Instructions

1. *This form is here to help you speak up safely. Your voice matters. Use it to share concerns, ask for help, or suggest changes—big or small.*
2. Use this form as a guide when you need to file a complaint or provide feedback.
3. You can either call the patient advocate directly, complete this form and submit a copy to the Patient Advocacy office or use this as a guide to write your own personal letter.

1. Feedback Type (Check One)

- ☐ **Complaint** = day-to-day issue (e.g., long wait times)
- ☐ **Grievance** = serious concern (e.g., neglect, disrespect, harm)
- ☐ Suggestion for Improvement

2. Patient Info

- a. Name: _____
- b. Date of Birth: _____
- c. Date of Service: _____

3. Name of person helping you (optional):

- a. Relationship: _____
- b. Do you give permission for them to speak on your behalf? ☐ Yes ☐ No

4. Date & Location of Incident / Experience

- a. Date: _____
- b. Department / Unit / Facility: _____

5. Individuals Involved (Providers, Staff, Other Patients)

- a. Name (if known): _____
- b. Role/Relationship: _____
- c. Other Description: _____

6. Detailed Description of Incident / Experience

What happened? (Be as specific as possible)

How did this affect you? (Physically, emotionally, financially, etc.)

7. Desired Resolution or Outcome



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For complaints:

8. Preferred response method:

☐ Email ☐ Phone ☐ In writing ☐ No response needed

9. **Additional Supporting Documents (Check all that apply)**

- ☐ Medical records / test results
- ☐ Photographs
- ☐ Witness statements
- ☐ Bills / receipts / invoices
- ☐ Other: _____