Patient Name:

DOB:

MR #:

**UW Health**
**(SwedishAmerican Hospital)**
**PATIENT GRIEVANCE FORM**

Event Date: _____ Department: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Home Phone: _____ Cell Phone: _____

Person completing form, if not patient: _____

Please provide a detailed explanation of your concern. Please describe who, what, when, where, and how if possible.

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Please describe your expectation for resolution. Use the back of this form, if necessary.

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If you prefer, you may call the Patient Relations office at (779) 696-3898. You may also report concerns directly to the Illinois Department of Public Health at (800) 252-4343 or The Joint Commission at https://www.jointcommission.org/resources/patient-safety-topics/report-a-patient-safety-event