Los Angeles General Medical Center

LOS ANGELES GENERAL MEDICAL CENTER

Patient/Visitor Grievance Form

Please provide as much detail as possible so your grievance can be investigated thoroughly

DATE: _____

COMPLAINANT'S NAME: _____ _____
LAST FIRST TELEPHONE NUMBER

ADDRESS: _____
STREET CITY STATE ZIP CODE

PATIENT'S NAME: _____ _____
LAST FIRST RELATIONSHIP

MRUN: _____ DATE/TIME OF OCCURENCE: _____/_____

DEPARTMENT/LOCATION OF EVENT: _____
(Facility, Room, Ward, etc.)

PLEASE DESCRIBE THE NATURE OF THE ISSUE (ATTACH ADDITIONAL SHEETS IF NEEDED): _____

WHAT WOULD YOU CONSIDER A PROPER SOLUTION TO THIS ISSUE? _____

Please return this form to your local member services department for processing. You will be contacted should additional information be required. Thank you.

Staff Instructions: Sign, date & provide a copy to complainant. **Send a scanned copy to** patientgrievances@dhs.lacounty.gov and forward ORIGINAL to: Patient Relations IPT, 2N115

Name of Supervisor/Administrator Providing Form:	**Location:**	**Telephone Number:**	**Date Received:**

DO NOT PLACE IN PATIENT'S HEALTH RECORD

Revised 01/18/23