COUNTY OF LOS ANGELES-DEPARTMENT OF HEALTH SERVICES

AMBULATORY CARE NETWORK

PATIENT RELATIONS COMMENT FORM

Patient Name:	Today's Date	Medical Record Number:	Date of Birth
Address:		Telephone number(s):	
Facility/Clinic/Area involved:		Date and time of occurrence:	
Name of Staff Involved, if applicable:			

☐ Compliment ☐ Complaint ☐ Suggestion

Name of Person Filing Comment
(Complete this section ONLY if the person commenting is NOT the patient named above):

1. Name: ______________________________
2. Relationship to Patient: ______________________________
3. Contact phone number(s): ______________________________
4. Email: ______________________________

Categories of Comment

☐ Customer Experience
☐ Behavior/Attitude of staff
☐ Access to care
☐ Communication
☐ Facility/Environment
☐ Medical Records
☐ Financial/Billing/Registration
☐ Quality of care

Comment: [If applicable, please include how you would like us to correct the issue.]