Patient Name:		**PF #**	

LOS ANGELES COUNTY ◊ ANTELOPE VALLEY REGION
PATIENT COMPLAINT FORM

SITE: ☐ **HIGH DESERT REGIONAL HEALTH CENTER**
☐ Urgent Care ☐ Primary Care ☐ Specialty ☐ Ambulatory Surgery Center
☐ **SOUTH VALLEY CLINIC**
☐ Urgent Care ☐ Primary Care ☐ Specialty
☐ **ANTELOPE VALLEY HEALTH CENTER**
☐ Prenatal/GYN ☐ Primary Care
☐ **LAKE LOS ANGELES CLINIC**
☐ **LITTLE ROCK CLINIC**

	HOME#	CELL#
PATIENT PHONE#		
FINANCIAL COVERAGE:		
DATE & APPROX TIME OF SERVICE:		
DATE OF COMPLAINT:		
SERVICE(S) INVOLVED:		
STAFF/PROVIDER INVOLVED:		

COMPLAINT:

WHAT DOES PATIENT/FAMILY WANT DONE:

R:\HDHRM\PCFORM03.DOC
DATE OF REVISION: 8/28/07/ln