LAKESHORE COMMUNITY HEALTH CARE
REPORT OF PATIENT CONCERNS / COMMENTS

We are here to help you if needed. Please ask any staff member if you require assistance in completing this form.

Date of Incident_____ Time_____ Today's Date_____

Patient's Name _____ Telephone _____

Address_____ Zip code _____

Your Name _____

Staff Member(s) _____

Involved Location of_____

Clinic

PATIENT DESCRIPTION OF EVENTS (please use back of form if necessary).

HOW WOULD YOU SUGGEST THAT WE SOLVE THIS PROBLEM?

Thank you very much for this information. Please give this completed form to any LCHC staff member. You may request a copy of this form. Someone from Lakeshore Community Health Center will contact you by mail or phone.