SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY

HHS PATIENT/CLIENT COMPLAINT FORM

Patient/Client Information ***Please write "anonymous" if you wish to remain anonymous**	
***Patient/Client Name or MRN #:**	**Patient/Client Phone:**
Patient/Client Email:	**What is your preferred mode of communication:** □ **Phone** □ **Email**

Program Area:

- □ Behavioral Health
- □ Dental
- □ Imaging
- □ Lab
- □ Optometry
- □ Pediatrics
- □ Pharmacy
- □ Physical Therapy
- □ Podiatry
- □ Primary Care
- □ Public Health
- □ Patient Registration
- □ Scheduling
- □ Walk In Clinic
- □ Other _____

Complaint Information	
Complaint Date:	Date of Visit:
Form Completed by:	
Complaint Details (Please state the details of why you are upset):	
How to Resolve (Please state how you would like to see this issue resolved):	

*****Completed forms may be placed into the white locked boxes throughout our facilities, given to the Patient Advocate staff or sent via email to QM@srpmic-nsn.gov*****