**COMMUNITY HEALTH NETWORK OF SAN FRANCISCO**
**SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER**
**1001 POTRERO AVENUE**
**SAN FRANCISCO, CA 94110**
**PATIENT ADVOCATE OFFICE ● ROOM 1Q1 ● OUTPATIENT LOBBY**
**(415) 206-5176 ● FAX (415) 206-8878**

# PATIENT CONCERN STATEMENT

TODAY'S DATE: _____ TIME: _____ PLEASE SEND COMPLETED FORM TO ABOVE ADDRESS

***PART I. PATIENT INFORMATION***

PATIENT NAME: _____ DATE OF BIRTH: _____ MR #: _____
MEDICAL RECORD #

ADDRESS: _____
STREET CITY STATE ZIP CODE

TELEPHONE: ( ) _____ HEALTH PLAN: ☐ None ☐ Medi-Cal ☐ Other- _____

NAME OF YOUR USUAL DOCTOR/ NURSE PRACTITIONER & LOCATION: _____

***PART II. CONCERN STATEMENT***

DATE OF OCCURENCE: _____ TIME OF OCCURENCE: _____

LOCATION(S)/ DEPARTMENT(S) INVOLVED: _____

SUMMARY OF CONCERN (WHAT HAPPENED?). PLEASE INCLUDE NAMES AND/OR POSITION OF STAFF INVOLVED, IF KNOWN: __

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**PLEASE FILL OUT PARTS I, II, & III** **USE AN ADDITIONAL SHEET IF NECESSARY**

2-086 (Rev. 05/05)

***PART III. CONCERN RESOLUTION***

THANK YOU FOR TELLING US ABOUT YOUR CONCERN. PLEASE TELL US THE BEST WAY TO REACH YOU SHOULD WE NEED MORE INFORMATION: ☐ WRITE TO ME ☐ CALL ME ☐ I WILL CALL YOU

SIGNATURE OF PATIENT: _____

NAME/ ADDRESS / PHONE # OF ☐ SPOUSE ☐ FAMILY MEMBER ☐ VISITOR WRITING CONCERN:

_____

NAME ADDRESS CITY ZIP CODE PHONE

NAME/ TITLE/ PHONE # OF STAFF PERSON WRITING CONCERN: _____

_____

***<u>FOR INTERNAL USE ONLY</u>***
***PART 1V. CONCERN DISPOSITION***

REVIEWED BY: _____ TODAY'S DATE: _____ CONCERN CODE(S): _____

DEPARTMENT(S) INVOLVED: _____ STAFF INVOLVED: _____

SUMMARY: _____

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***PART V. RESOLUTION***

DATE RESOLVED: _____ LETTER OF RESOLUTION REVIEWED BY: _____

DATE LETTER OF RESOLUTION MAILED TO PATIENT/ FAMILY: _____

DATE OF RESOLUTION MEETING OR CALL: _____

SUMMARY OF RESOLUTION: _____

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***SUMMARY OF RESOLUTION (CONTINUED)*** ***NAME:*** _____