

# PATIENT FEEDBACK FORM

Please give completed form to the Clinical Practice Manager,  
Navnit Sekhon: nsekhon@clemson.edu, 865-656-7422

Patient/Client Name: \_\_\_\_\_ CUID #: \_\_\_\_\_

Address: \_\_\_\_\_

Patient/Client Phone # (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Service: \_\_\_\_\_ Provider: \_\_\_\_\_

Name of Person Making Report (if different from above): \_\_\_\_\_

Relationship to Patient/Client: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please provide a detailed description of the feedback (attach additional sheets if necessary): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Person Filing Report: \_\_\_\_\_ Date: \_\_\_\_\_

Information Taken via Telephone

<b><u>FOR REDFERN HEALTH CENTER ONLY</u></b>	Date of Receipt of Complaint: _____
Action Taken: _____	
_____	
_____	
Signature of RHC Representative: _____	
<i>After complaint resolution, forward form to the Quality Improvement Manager.</i>	

Please visit our website at [clemson.edu/studenthealth](http://clemson.edu/studenthealth).

