



Quality
Insights

Renal Network 4

PATIENT GRIEVANCE FORM

All information will be kept confidential. Complete all blanks that relate to your concern.

Return this completed form to Quality Insights Renal Network 4 (see address below).

NAME: _____

ADDRESS: _____

DAYTIME PHONE #: _____

IF PHONE UNAVAILABLE, CAN WE LEAVE A MESSAGE FOR YOU AT YOUR DIALYSIS FACILITY? YES NO

FACILITY/UNIT ASSOCIATED WITH THE GRIEVANCE:

NAME: _____

ADDRESS: _____

DIALYSIS SCHEDULE _____

GRIEVANCE INVOLVES (Check all specifically involved):

Facility/Unit Staff

Name: _____ Title: _____

Name: _____ Title: _____

Physician(s)

Name: _____

Name: _____

Other (specify) _____

Quality Insights Renal Network 4 · 1586 Sumneytown Pike #1470 · Kulpsville, PA 19443

Phone: 800-548-9205 · Fax: 610-783-0374

Please check the ONE that applies to you:

I have approached the facility with this grievance and am not satisfied with the outcome or handling. I am not satisfied because (specify reason):

I have not approached the facility with this grievance because (specify reason):

Please check ONE:

I choose to represent myself during this grievance process.

I have chosen a representative to help me during this grievance process.

Name: _____

Address: _____

Daytime Phone #: _____

Please check ONE:

I allow the Network to release my identity to the appropriate individuals in the processing of this grievance.

I wish to remain anonymous. I understand that remaining anonymous may result in the inability to fully process my grievance. I will be notified by the Network if this is the case.

Signature of Person Filing Grievance Date

Signature of Patient Representative (if applicable) Date

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