



HO-CHUNK NATION

DEPARTMENT OF HEALTH



Patient Feedback/Complaint Form

Please complete and submit the information requested on the Patient Feedback/Complaint form. Your feedback is very important to us. The Quality Improvement Director or representative of the Department of Health may contact you to obtain additional information.

The Department of Health will take every step necessary to protect any Personal Health Information (PHI) or Personal Identifying Information (PII) that may be disclosed in the Patient Feedback/Complaint form. The submission of this Feedback/Complaint for constitutes consent to use or disclose any PHI or PII to the minimum number of persons necessary who have a need to know to address any concerns raised in the report.

Person Reporting: (required) _____.

Mailing Address (of person reporting): _____.

Phone number (of person reporting): _____.

Email address (of person reporting): _____.

Which area of service did you use? (Check all that apply)

- Pharmacy
- Clinic/medical
- Environmental Health
- Not listed (*please write in*): _____
- Optical
- Clinic Registration
- Community Health
- Dental
- Benefits/billing
- Public Health
- Lab/radiology
- Behavioral Health

Location of Incident:

- Patient's Home
- Nekoosa Health Office
- Non-Health Department facility
- Food Distribution
- Tomah Health Office
- Other (*please specify*): _____.
- HHCC
- Wittenberg Health Office
- HOW
- Madison Health Office
- La Crosse Health Office

Incident Date: _____.

People Involved: _____.

Incident Details: Please share your experience or provide information that explains or describes the incident you wish to report. Include the names of any witnesses that may have been involved or seen what happened.



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Patient Feedback/Complaint Form

(continued)

Wa'iniginapsana! Thank you! We value your time and your feedback.