



## Feedback Form

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Submitted by: \_\_\_\_\_

This concern is regarding my bill:  Yes  No

This concern is regarding my patient care:  Yes  No

Did you discuss this concern with a member of your health care team?  Yes  No

### REQUIRED

- **Who** was involved: \_\_\_\_\_
- Date **when** the issue occurred: \_\_\_\_\_
- Location **where** the issue occurred: \_\_\_\_\_

Please provide a brief statement about your complaint and how you would like to resolve your complaint:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By submitting this form to Patient Relations at St. Luke's Health System:

- I authorize the St. Luke's Patient Relations to review the above concern on my behalf.
- I understand that Patient and Family Relations will review my medical record and/or discuss my case with my health care provider(s).
- I understand that Patient and Family Relations will provide a written response by mail to the patient or appropriate patient representative upon completion of the review.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Return to:

St. Luke's Health System  
 ATTN: Patient and Family Relations  
 190 E. Bannock Street  
 Boise, ID 83712

(208) 381-1420 or 1-800-579-0061

[patientrelations@slhs.org](mailto:patientrelations@slhs.org)