ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL

Office of Patient Experience Grievance Procedure

Zuckerberg San Francisco General Hospital wants to provide you with quality health care in a respectful, compassionate manner. If we did not meet your expectations during your stay or visit, we want to hear about it.

Q: Who can submit a grievance?

A: Any patient/visitor may file or communicate a concern/grievance regarding their treatment. If you are unable to file or communicate a concern/grievance, a family member, spouse, or significant other may file a concern on your behalf.

Q: What happens after submitting a grievance/concern in writing?

A: Below is the concern process:

1) Our office will send an acknowledgement/confirmation that we have received your concern.
2) We will reach out to the department where the concern occurred.
3) The department lead will be reaching out to you via phone to learn more about your experience.
4) The department lead will conduct an investigation of the occurrence and provide you with response of the outcome within 30 business days.

If you have any questions, feel free to contact our office at:
Building 25, Room H1246
1001 Potrero Avenue
San Francisco, CA 94110
Phone: (628) 206-5176
Fax: (628) 206-8878
Email: dph-patientexperience@sfdph.org
PATIENT EXPERIENCE STATEMENT

Please submit completed form in person, by mail, fax or email to the Office of Patient Experience.

Today’s Date: ________________

PART I. PATIENT INFORMATION
Patient’s First Name: ___________________ Last Name: ___________________
Date of Birth: _______________ Medical Record #: ___________________
Address: ____________________________________________________________
Street
City State Zip Code
Telephone: ( ) ___________________________ Okay to leave a message? □ Yes □ No
Name of your usual/primary doctor/ nurse practitioner: _______________________
Primary Care Clinic/Location: ______________________________________________

PART II. STATEMENT (This form is for Grievances and Compliments)
Date of Occurrence: ____________
Time of Occurrence: ____________
Location(s)/ department(s) involved: _______________________________________
SUMMARY OF WHAT HAPPENED: Please include names and/or position of staff involved, if known:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
Please add more pages as needed

PART III. RESOLUTION

Please tell us the best way to reach you should we need more information:

☐ WRITE TO ME ☐ CALL ME ☐ I WILL CALL YOU ☐ EMAIL ME

SIGNATURE OF PATIENT:

____________________________________

NAME OF ☐ SPOUSE ☐ FAMILY MEMBER ☐ VISITOR WRITING STATEMENT:

____________________________________

Address  City  Zip Code  Phone/email

NAME/ TITLE/ PHONE # OF STAFF PERSON WRITING STATEMENT:

____________________________________

THANK YOU FOR TAKING THE TIME TO TELL US ABOUT YOUR EXPERIENCE.

All grievances will be investigated and we will provide you with an update within 30 business days.