MCDONALD ARMY HEALTH CENTER
PATIENT ASSISTANCE REQUEST FORM
Patient Representative: 314-7855

Please Circle One: ***AREA TO BE IMPROVED*** **or** ***COMPLIMENT***

PATIENT NAME:
_____

SPONSOR SSN:
(FMP)_____/_____

Person to Contact (if other than patient):
_____

Address _____City _____State _____ Zip _____
Telephone (Home) _____ (Work) _____

Sponsor's Service Branch (Please Circle One): USA USN USAF USMC USCG Other

Sponsor's Rank: _____ Sponsor's Status (Please Circle One): ACTIVE DUTY RETIRED OTHER

Encounter Date: _____

Clinic/Department Seen: _____ **Provider Seen**: _____

1) Problem Area or Area to be Complimented (Please Circle):
Access Courtesy Timeliness Diagnosis/Treatment Perception of Care Missing Health Records Other _____

2) Personnel Type Involved (Please Circle):
Med Records Clerk Receptionist Nurse Provider Pharmacist Technician Other _____

3) Time of Day of Incident (Please Circle One): Before 0900 0900-1200 1200-1400 1400-1700 After 1700

Comments
_____
_____
_____
_____
_____

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Comments (continued)