DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER
PATIENT EXPERIENCE OFFICE
Fort Gordon, Georgia 30905-5650

PATIENT EXPERIENCE CONSULTATION WORKSHEET

For use of this form, see DDEAMC Reg 40-100; the proponent agency is MCHF-PE.

Date: ________________
(YYYYMMDD)

Patient's Name: ______________________________ (Last) (First) (MI)
Sponsor's Name: ______________________________ (Last) (First) (MI)
Rank: ______

DoD ID: ____________________ Unit Assigned: ______________________________

Work Phone: ______________ Cell Phone: ______________ Home Phone: ______________

☐ Walk-In ☐ Phone-In ☐ Write-In

Patient Status: ☐ Active Duty ☐ Active Duty Family Member ☐ Retired ☐ Retired Family Member

INQUIRY:

(Continue on plain 8.5 x 11 plain paper if necessary.)

Would you like to be contacted? ☐ Yes or ☐ No

PRIVACY ACT STATEMENT: Disclosure of the social security number and other personnel information is voluntary; however,failure to provide complete information may hinder proper identification of the requester, accomplishment of the requested action(s) and response to the requester. This information may be furnished to other medical staff on a need-to-know basis.

I authorize the Patient Advocacy Office staff to take whatever action necessary to respond to my inquiry, to include my medical records and speaking with my health care providers, other individuals or agencies, as appropriate.

I give telephone consent to speak with me.

☐ Yes ☐ No

______________ Date

______________________________ (Signature of Patient)

PATIENT CONSULTATION WORKSHEET
(For Patient Experience Office use only)

1. Reason for Consultation:

- ☐ a. Routine Appointments: ☐ AC ☐ RT ☐ F/U ☐ WW ☐ O
- ☐ b. Consult Referral/Assistance
- ☐ c. Medical Documents
- ☐ d. Medical Lodging
- ☐ e. Medical Transportation
- ☐ f. TRICARE/Health Benefits
- ☐ g. Central Appointments Office
- ☐ h. Information Desk
- ☐ i. Customer Complaints
- ☐ j. HIPPA/Privacy
- ☐ k. Access to Care / Appointments
- ☐ l. Appointment Difficulties
- ☐ m. Continuity of Care
- ☐ n. Communications / Telephone / Website
- ☐ o. Compensatory Event
- ☐ p. Medical Treatment Related / PCE
- ☐ q. Pharmacy Problems
- ☐ r. Electronic Profile Problem
- ☐ s. PCM / Primary Care Manager
- ☐ t. Erroneous Information
- ☐ u. Lost Records
- ☐ v. Lost Item
- ☐ w. Documentation Failure
- ☐ x. Patient Safety
- ☐ y. Hospital Policies
- ☐ z. Health Care Resolution:
- ☐ aa. Consult Resolution / Facilitation and Mediation
- ☐ bb. Other:

2. CONGRESSIONAL COMPLAINTS: ☐ OMBUD ☐ IG ☐ ICE

3. SUMMARY (Includes Corrective Action - see attachment):

Department: ______________________

Clinic/Section: ______________________

________	______________________	________	______________________
Date	Patient Advocate Signature	Date	Department Chief Signature