

University of Louisville School of Dentistry
QUALITY ASSURANCE CONCERNS

For Office Use Only	
ULSD Patient #: _____	
QA Concern	<input type="checkbox"/> Yes <input type="checkbox"/> No

Although we strive to provide quality work and service, in the event that you have had an unpleasant experience with us, we would like to know so that we can address it in a timely manner and correct the situation.

Please complete the information below. Your concern will be addressed within two weeks, and you will receive notification of the outcome by telephone and/or mail. All concerns relating to privacy issues will be referred to the Privacy Officer. Again, we apologize for any inconvenience you may have encountered, and we thank you in advance for helping us improve our services.

I AM A: (please check appropriate box)

DATE: _____

<input type="checkbox"/> Patient Name:		Birthdate	
<input type="checkbox"/> Visitor Name:		Telephone Number	
<input type="checkbox"/> Student Name:		DMD <input type="checkbox"/>	Grad <input type="checkbox"/> DH <input type="checkbox"/>
<input type="checkbox"/> Employee Name:			
<input type="checkbox"/> Faculty Name:			

MY CONCERN INVOLVES (please check one)

<input type="checkbox"/> Timeliness of Care	<input type="checkbox"/> Infection Control
<input type="checkbox"/> Financial Problem	<input type="checkbox"/> Communication
<input type="checkbox"/> Lack of Professionalism	<input type="checkbox"/> Privacy
<input type="checkbox"/> Other	<input type="checkbox"/> Radiographs (bitewings/FM)
<input type="checkbox"/> Quality of Service/ Care <input type="checkbox"/> Filling (Restorative/Operative) <input type="checkbox"/> Root canal (Endo) <input type="checkbox"/> Gums (Perio) <input type="checkbox"/> Extractions (Oral Surgery) <input type="checkbox"/> Denture (Pros) <input type="checkbox"/> Implants (Oral Surgery) <input type="checkbox"/> Implants (Perio) <input type="checkbox"/> Bridge/RPD (Pros) <input type="checkbox"/> _____	

Comments - Please use back of form for additional comments if necessary

Concern resolved by (date): _____ Resolution Pending

FOR OFFICE/FACULTY USE ONLY

Financial Adjustment (post delivery remakes) Applies to Faculty Only Explanation required - (on back of form please)	Financial Adjustment (All other clinical procedures, excluding post delivery remakes)
Approval for financial adjustment <input type="checkbox"/> Granted <input type="checkbox"/> Denied	
Office of Clinical Affairs	

RETURN TO THE OFFICE OF CLINICAL AFFAIRS WHEN RESOLUTION OR ACTION PLAN HAS BEEN ESTABLISHED

