|  |  |  |
| --- | --- | --- |
|  | **PATIENT / PATIENT'S RELATIVE****THANKS, WISHES/SUGGESTIONS AND COMPLAINT FORM** | Açıklama: C:\Users\SEHERE~1\AppData\Local\Temp\Rar$DIa0.214\sağlık_bakanlığı_logo.png |
| Document Code | HD.FR.01 | First Release Date: | 25.08.2016 | Rev. Date: | 5.12.2023 | Rev. No: | 01 | Page Number: | 1 / 1 |

|  |  |  |
| --- | --- | --- |
|  | **PATIENT / PATIENT'S RELATIVE****THANKS, WISHES/SUGGESTIONS AND COMPLAINT FORM** | Açıklama: C:\Users\SEHERE~1\AppData\Local\Temp\Rar$DIa0.214\sağlık_bakanlığı_logo.png |
| Document Code | HD.FR.01 | First Release Date: | 25.08.2016 | Rev. Date: | 5.12.2023 | Rev. No: | 01 | Page Number: | 1 / 1 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  This form has been prepared by our Institution's Patient Rights Unit to provide you with better service. If you fill in the information requested below, it will be possible to give you feedback about the transaction. ***Please tick the box below that suits you!***  **PATİENT THE RELATIVES OF THE PATIENT**

|  |  |  |  |
| --- | --- | --- | --- |
| History: |   | Unit from which you receive service: |  |
| Patient name and Surname: |  | Your Professiion / Your Age: |  |
| Telephone: |  | E-mail: |  |
| \*Patient’s relativefilling out the form Name Surname: |  |
| Address: |

 |
| ***Please, tick the box that you think is related to the topicyou want to report.*** **WİSH/SUGGESTİON THANK COMPLAINT** |
| **SUBJECTU:** |
|  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   This form has been prepared by our Institution's Patient Rights Unit to provide you with better service. If you fill in the information requested below, it will be possible to give you feedback about the transaction. ***Please tick the box below that suits you!*** **PATİENT THE RELATIVES OF THE PATIENT**

|  |  |  |  |
| --- | --- | --- | --- |
| History: |   | Unit from which you receive service |  |
| Patient Name and Surname: |  | Your Profession/ Your Age: |  |
| Telephone: |  | E-mail: |  |
| \*Patient’s relative filling out the form Name Surname: |  |
| Address: |

 |
| ***Please tick the box that you think is related to the topic you want to report.*** **WİSH /SUGGESTION THANKS COMPLAINT** |
| **SUBJECT:** |
|  |