PAWNEE Mental Health Services
COMMENT FORM
Protected Pursuant to KSA 65-4915

Name: _____ Phone: _____

Date: _____ Time: _____

Received by: ☐ Phone ☐ Mail ☐ In Person

Regarding: ☐ Program ☐ Facility ☐ Person

Pertaining to: ☐ Quality ☐ Attitude ☐ Access ☐ Other _____

COMMENT: (Include all relevant information, including date and time.)

Forward to: Risk Manager, Jennifer Walters Date: _____

Do not duplicate. Do not file in medical record. Privileged and confidential. For internal use only.