



SIoux LOOKOUT
Meno Ya Win
HEALTH CENTRE

COMPLAINT FORM

Attention: VP Health Services
Sioux Lookout Meno Ya Win Health Centre
PO Box 909, Sioux Lookout, ON P8T 1B4

*This form is to be utilized for both internal patient complaints and external patient/public complaints.
If required, please provide assistance to the complainant while completing the form.*

SECTION (I)

Section (I) to be completed by Complainant

| | | | |
|--|------------|---------|---|
| Date/Time of Complain | (dd/mm/yy) | (hh/mm) | Complaint No: <i>To be completed by facility.</i> |
| Date/Time Report Completed | (dd/mm/yy) | (hh/mm) | Date Entered in Risk Pro: <i>To be completed by facility.</i> |
| Reported to: (name & title) | | | |
| Complainant Contact Information (Name/Address/Telephone #/Best Time to Reach/E-mail Address) | | | |
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| | | | |
| Description of Complaint (Who/what/when/where/why/how the complainant is affected. Use complainants words as much as possible) Privacy Related: In own words what transpired, including what and how much personal health information was affected; the circumstances surrounding the breach, date & time of occurrence. Take an inventory of Personal Health Information involved: type, information contained, location, backup copies, security, retention, notes. Use additional pieces of paper, if necessary. | | | |
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| Who Was involved (patient/staff) | | | |
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| Immediate steps taken to control or reduce the harm | | | |
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| If you are completing this form on behalf of a client, please fill out your information on the space below. | | | |
| Full name and contact information. | _____ | | |
| | _____ | | |

Photocopy Section (I) and forward to the Vice President of Health Services' office for assignment of Complaint No.

Relationship to client: _____ **Signature:** _____



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SECTION (II)

Section (II) to be completed by Department Manager or Designate

| |
|---|
| Complaint No: <i>To be completed by facility.</i> |
|---|

| | | Staff Resp. | Target Date |
|--|---|-------------|-------------|
| 1. Outline Action Plan | | | |
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| 2. Outline results of follow up investigation of the Incident. | | | |
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| Forward completed Sections (I) and (II) to: | <input type="checkbox"/> Vice President Health Services <input type="checkbox"/> Executive Assistant to the Vice President of Health Services | | |
| | <input type="checkbox"/> Dept. Manager _____ Date forwarded _____ <input type="checkbox"/> Chief Executive Officer <i>(Please Identify)</i> <input type="checkbox"/> Vice President Corporate Services <input type="checkbox"/> Chief of Staff <input type="checkbox"/> Quality/Risk Management Manager | | |
| <input type="checkbox"/> Please check box if other information is attached. | | | |

_____ **Department Manager***

_____ **Date**

*This certification must be signed by the person investigating the complaint.