Trent Hills Family Health Team	Patient Complaint Form

Date: _____

Person Registering the Complaint

First Name: _____ Last Name: _____

Address: _____

Daytime Phone Number including area code: _____

Evening Phone Number including area code: _____

E-Mail Address: _____

Patient Information (if other than the person registering the complaint)

First Name: _____ Last Name: _____

Address: _____

Daytime Phone Number including area code: _____

Evening Phone Number including area code: _____

E-Mail Address: _____

Details of Complaint:

Please provide details of your concern including the following as appropriate/applicable:

Date and time of the incident: _____

Which clinic? ☐ Campbellford ☐ Colborne ☐ Hastings ☐ Havelock ☐ Warkworth

What is your complaint/concern? _____

_____

_____

_____

_____

_____

Name of the healthcare team member(s) involved: _____

_____

Describe any efforts you have made to resolve this matter: _____

Please describe the result or outcome that you seek: _____

Do you consider this matter urgent? ☐ Yes ☐ No

If yes, please explain why: _____

Further comments: _____

You may use the back of this form as needed.

Please forward the completed form to:

Delayne Donald
Executive Director
Trent Hills Family Health Team
119 Isabella Street
Campbellford, Ontario K0L 1L0

E-mail: admin2@thfht.com
Fax: 705-653-0849

For Office Use Only

Complaint received by: _____ **Date:** _____

Complaint investigated by: _____ **Date:** _____

Date response sent to client: _____ **Resolved:** ☐ **YES** ☐ **NO**