PATIENT COMPLAINT FORM

WEST CHAMPLAIN
FAMILY HEALTH TEAM

Person Registering the Complaint

First Name Last Name

Daytime Phone Evening Phone

( ) ( )

Email

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

First Name Last Name

Relationship to Complainant

Daytime Phone Evening Phone

( ) ( )

Email

Details of Complaint

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

- The specific program or service you are concerned about?Why?
- Dates and location of service or program participation
- Name of the healthcare team member you are concerned about
- Description of efforts you have made to resolve this matter with the healthcare team member.

In addition, please describe the result or outcome that you seek. If you consider the matter urgent, please explain why.

Signature of Patient Date

Please complete this form and return it to a member of reception in person, *or* email it to:
admin@westchamplainfht.com