**Highlands Health Network**

**Complaint Report**

Highlands Health Network is committed to providing high quality service to our patients. We listen to your complaints, treat them seriously, and learn from them so that we can continuously improve our service.

Formal complaints procedure:

1. Complete Complaint Report
2. Mail or return to 140 Rolling Hills Dr. Orangeville ON L9W 4X8
3. The Clinic Manager will acknowledge receipt of the complaint within a reasonable time frame (approximately one week)
4. The Clinic Manager will then follow-up with the person(s) involved to review the outcome of the incident

To be completed by complainant:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person(s) Involved: [ ]  Staff [ ]  Physician [ ]  Student/Resident

Name of person involved (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of incident (what occurred, when, where, who was involved):

|  |
| --- |
| For Office Use Only |

(Part B)

To be completed by the person(s) involved: [ ]  Staff [ ]  Physician [ ]  Student/Resident

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Description of incident:

(Part C)

To be completed by the Clinic Manager:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Steps planned/corrective action to prevent further occurrence of the incident:

(Part D)

[ ]  Acknowledged receipt of complaint form Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Discussed with person(s) involved Date resolved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_