Formal Patient Complaint/Concern Form

Date:

Person Registering the Complaint

First Name:
Last Name:
Address:
Phone:
Email Address:

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

First Name:
Last Name:
Address:
Phone:
Email Address:

Relationship to Patient

[ ] Parent (child is under 16 years of age and/or for whom I am legal guardian)
[ ] Parent, legal guardian or attorney for a dependent adult
[ ] I am the Substitute Decision Maker for the above patient
[ ] I am a friend of the above patient
[ ] I am a neighbor/acquaintance of the above patient

Details of the complaint

Provide details of your concern including the following as appropriate/applicable
Date of Incident:
Time of incident:
Was this regarding an appointment [ ] YES [ ] NO

Name of the team member(s) of our clinic involved:

Provider (doctor):
Receptionist:
Other:

What is your complaint/concern:

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:

Signature of person registering the complaint: _____

Upon submission, this document will be reviewed by our Operations Supervisor (or delegate).

Please email the completed form to info@doctormarczuk.ca (make sure all fields are filled out).

If not able to email, then you can mail it to:

595 Wonderland Rd N
London, ON N6H 3E2
ATTN: Operations Manager