COMMENT FORM

Reason for Filling in Form:

☐ Concern ☐ Congratulations

☐ Complaint ☐ Recommendation

Date received: _____ Occurrence date: _____

Patient's name: _____ Department/Room Number: _____

Home address: _____ Telephone: Residence: _____

Work: _____

Letter from Patient/Family attached? Yes ☐ No ☐

Relationship to the Patient: Self ☐ Spouse ☐ Child ☐ Parent ☐ Friend ☐

Other ☐ _____

Are you the legal decision maker? Yes ☐ No ☐

(Verbal/written consent is required if the form is filled out on behalf of someone else and you are not the legal decision maker.)

Name of staff member/area you want to comment on: _____

I want to address:

☐ Communication Style ☐ Management of Patient Care

☐ Health Records or Report Completion ☐ Availability of Staff

☐ Staff Courtesy ☐ Interdisciplinary Issues

☐ Finding Your Way ☐ Noise Level

☐ Financial/Billing ☐ Confidentiality

☐ Office Cleanliness ☐ Other _____

Please explain the experience or event you would like to share:

_____

_____

_____

_____

_____

Signature/Title/Department: Patient ☐ Visitor ☐ Staff ☐

FORWARD COMPLETED FORM TO QUALITY AND RISK MANAGEMENT DEPARTMENT

List persons, services or departments involved (please check all that apply):

DO NOT SEND: Quality and Risk Management will notify the appropriate departments

☐ President ☐ Vice President: _____ ☐ Privacy Officer
☐ Chief of Staff ☐ Chief of Service: _____ ☒ Quality Management
☐ Director/Manager: _____ ☐ Others (please list): _____

Lead: _____

Standard: "Acknowledge receipt of the occurrence verbally or in writing within 14 days. If necessary, follow-up with resolution to be complete within 45 days."

How may we contact you? ☐ Email _____ ☐ Postal Service
☐ Daytime/Evening Telephone Number: _____

Action Taken by Investigating Manager/Physician Date: _____

Please forward copies of Action Taken to the following (please check all that apply):

☐ Vice President: _____ ☒ Quality Management
☐ Medical Staff Office ☐ Others (please list): _____

Signature: _____

Comment Form Instructions

We appreciate your feedback. Please let us know if you would like to highlight something we are doing well or identify opportunities to improve your experience of care.

Please fill in the form completely so we have the information to respond promptly and appropriately.
We will notify you either verbally or in writing within 14 days of receiving this form and will provide follow-up communication within 45 days when necessary.

Thank you for taking the time to share your care experience at Thunder Bay Regional Health Sciences Centre. Your feedback and partnership will help us improve the experience of care for every patient, every time by Caring Together.