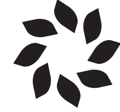
COMMENT FORM



Thunder Bay Regional Health Sciences Centre

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:

____
____
____
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____

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