MEDICAL ASSOCIATES of PORT PERRY

Formal Patient Complaint/Concern Form

Date: _____

Person Registering The Complaint

First Name:
Last Name:
Address:
Daytime Phone:
Evening Phone:
Email Address:

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

First Name:
Last Name:
Address:
Daytime Phone:
Evening 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 Health care team member(s) involved:
Provider (Doctor, other healthcare professionals):

Nurse:

Receptionist:

Other:

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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:

Upon submission, this document will be reviewed by our Operations Manager. We will attempt to provide acknowledgement of receipt within 5 business days.

Email may not be secure. While we try to protect our emails we cannot guarantee the security and confidentiality of any email you send to or receive from us. If you have security concerns please mail or deliver your form to the office.

Print

Email