



FEEDBACK FORM

*This form is to be utilized for both internal and external patient/public feedback.
If required, please provide assistance while completing the form.*

SECTION (I)

Section (I) to be completed by originator of feedback.

Date/Time of Feedback	(dd/mm/yy)	(hh/mm)	RiskPro File Number: <i>To be completed by facility.</i>
Date/Time Report Completed	(dd/mm/yy)	(hh/mm)	Date Entered in Risk Pro: <i>To be completed by facility.</i>
Reported to: (name & title)			
Originator of Feedback Contact Information (Name/Address/Telephone Number and best time to reach/E-mail address)			
Description of Feedback (Who/what/when/where/why/how the individual is affected. Use the individual's words as much as possible) Use additional pieces of paper, if necessary.			
Who Was involved (patient/staff)			
Immediate steps taken to control or reduce the harm			
<i>If you are completing this form on behalf of a client, please fill out your information on the space below.</i>			
Full name and contact information.	_____		

Forward completed form to the Director of Patient Experience.

Relationship to client: _____ **Signature:** _____



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SECTION (II)

RiskPro File Number: <i>To be completed by facility.</i>
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		Staff Resp.	Target Date
1. Outline Action Plan			
2. Outline results of follow up review of the incident.			
Forward completed Sections (I) and (II) to:	<ul style="list-style-type: none"> By letter – Attention; Director of Patient Experience Sioux Lookout Meno Ya Win Health Centre, Box 909, Sioux Lookout, ON P8T 1B4 Using the Feedback Form – available from any staff member or from www.slmhc.on.ca By e-mail at feedback@slmhc.on.ca By phone at (807) 737-6587 By Fax at (807) 737-6251 In person – to any staff member 		

Signature

Date

*This certification must be signed by the person reviewing the feedback.