

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.

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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/Email Address/Telephone Number/Mailing Address and best time to contact/E-mail)			
Description of Feedback (Who/what/when/where/why/how the individual is affected. If completing on behalf of patient, 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			
<input type="checkbox"/> <i>Check the box if you consent to having our appropriate staff review your file in case feedback is escalated.</i> <i>If you are completing this form on behalf of a client, please fill out your information in the space below.</i>			
Full name and contact information			
Forward completed form to the Quality and Patient Safety Lead.			
Relationship to client:	Signature:		

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SECTION (II)

RiskPro File Number:

To be complete by facility.

1. Outline Action Plan		Staff Resp.	Target Date
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; Quality and Patient Safety Lead ○ 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) 737-6578 ○ By Fax at (807) 737-5284 ○ In person – to any staff member
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_____ Signature	_____ Date
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*This certification must be signed by the person reviewing the feedback.