Owen Sound Family Health Organization
OSFHO

Patient Complaint Form

Date:

Person Registering the Complaint	
First Name	Last Name
Address	
Daytime Phone Number + Area Code	
Evening Phone Number + Area Code	
Email Address	

Patient Information (if other than the person above)	
First Name	Last Name
Address	
Daytime Phone Number + Area Code	
Evening Phone Number + Area Code	
Email Address	

Details of the Complaint	
Date if the Incident:	
Was this a CLINIC visit: Yes____ No ____ Was this a PROGRAM visit: Yes____ No ____	
Name of Healthcare team member(s) involved	
Doctor:	Nurse:
Receptionist:	Other:
Details:	

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Describe any efforts you have made to resolve this matter:
Please describe the result of or outcome that you seek:
Do you consider this matter urgent: Yes____ No ____
If yes, please explain why:

Please forward the completed form to:

Karen Smith-Turner
Executive Director
Owen Sound Family Health Team
1415 1st Ave W, Suite 2000
Owen Sound, ON N4K 4K8

EMAIL: ksmithturner@osfht.ca
FAX: 519-470-3035

FOR OFFICE USE ONLY	
Complain received by	Date
Complaint Investigated by	Date
Date response sent ot client	Resolved Yes ____ No ____