PATIENT COMPLAINT FORM

MMI is committed to providing our patients with the best level of care possible. Please complete this form if you have concerns about the health care or treatment that you or a family member received at one of our clinics.

PATIENT INFORMATION

Patient Name: _____ DOB: _____

OHIP Number: _____

Address: _____

Telephone Number: _____ Email Address: _____

COMPLAINANT INFORMATION (IF DIFFERENT FROM ABOVE) Please also complete and fax the Health Information Authorization Form if filling it out on behalf of patient.

Name of person initializing complaint: _____

Phone Number: _____ Email Address: _____

Relationship to Patient: _____

NATURE OF COMPLAINT

☐ Appointment/Booking ☐ Problem with Staff ☐ Other: _____

Date & Time of Incident: _____

Clinic Location: _____

Exam/Service provided: _____

DETAILS OF YOUR COMPLAINT

In your own words please tell us why you were unhappy with the care or service you received.

_____
_____
_____
_____
_____
_____

I understand that the staff investigating this complaint may need to see and review my health records, but that all information will be kept confidential. I further understand that this complaint will in no way affect any care provided.

Signature: _____ Date: _____

Please fax the completed form to 365-447-0053 (If outside the Niagara Region include 1 in front of area code)
You should receive a response within 10 business days. (If the complaint alleges harm or risk of harm, it will be dealt with immediately)

If you are not happy with the resolution of the complaint, it is your right to bring your complaint to the Patient Ombudsman under the Excellent Care for All Act, 2010
Mail: Box 130, 77 Wellesley St., West, Toronto, ON, M7A 1N3
Phone: 416-597-0339 Toll Free: 1-888-321-0339 Website: patientombudsman.ca