LAKE OF THE WOODS DISTRICT HOSPITAL
COMPLAINT FORM

Date Complaint Received: _____ Date of Incident: _____

Client/Family Member's Name: _____ Department: _____ Room No.: _____

Home Address: _____

Telephone: Residence _____ Employment _____

Letter from Client/Family attached? Yes ☐ No ☐

A. Describe the Complaint:

A verbal complaint made by the client, family member or friend MUST be described in his or her own words by using "Quotation Marks":

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B. List other persons, services or departments involved:

_____

_____

_____

Signature of Complainant: _____ Date: _____

Signature of Staff Completing: _____ Title/Dept: _____

Please submit via fax to (807) 468-3939 or via email to admin@lwdh.on.ca

C. Follow-up Actions Taken by Investigating Manager/Director/Physician:

D. List the Outcomes of the Investigation including corrective measures if any:

Copy to: _____

Signature: _____ Date: _____

(Manager/Director/Physician)