WAHA Client Concern Form

NOTE: if you wish to remain anonymous, please indicate in your concern. If you **remain** anonymous, WAHA will not be able to contact you to obtain additional information or notify you of the results.

Attention:
Weeneebayko Area Health Authority
Quality Dept., 3rd Floor, Rm. 314
19 Hospital Drive, Box 664
Moose Factory, ON P0L 1WO **(Fax) 705-658-4917**
email:
patientsatisfaction@weeneebaykohealth.ca

Date the Concern was submitted to WAHA staff.	(dd/mm/yy)	(hr/min) ☐ AM ☐ PM	**Concern # (*filled out by WAHA*):**
Concern Reported to: (name and title of WAHA staff)			
Contact Information (person filing the concern) (Name/Address/Phone# Email/Best Time to Reach)			**OR** ☐ **I wish to remain anonymous** (please check)
Description of the Concern Who/What/Where/When How/Why? What is the concern about? • Description of the incident. • Date of incident. • Time of incident. • Location of incident. • Did the incident happen more than once? Individuals involved - any witnesses? Did you raise the concern with someone at WAHA? If so, whom? In your opinion, has WAHA tried to address the issue? **Use additional pieces of paper if necessary.**			
If you are completing this form on behalf of a patient you have permission to speak on their behalf.	**Provide your full name and contact information** (Name/Address/Phone#/E-mail/Best Time to Reach)		
Relationship to Patient:		**Signature:**	

Date Created: April 1, 2011 Updated: November 6, 2013; January/June 2014