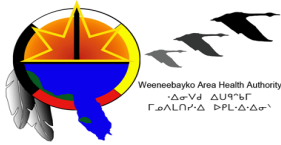


WAHA Client Concern Form



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 1W0 **(Fax) 705-658-4917**
email:
patientsatisfaction@weeneebaykohealth.ca

Date the Concern was submitted to WAHA staff.	(dd/mm/yy)	(hr/min) <input type="checkbox"/> AM <input type="checkbox"/> 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)			<p style="color: red;">OR</p> <p style="color: red;"><input type="checkbox"/> I wish to remain anonymous (please check)</p>
Description of the Concern Who/What/Where/When How/Why? What is the concern about? <ul style="list-style-type: none"> • 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:	