Patient Ombudsman
Ombudsman des patients

COMPLAINT FORM

Complete all sections of this form and send it back to us. Please contact us if you need help filling out the complaint form. See page 4 for contact details.

The Patient Ombudsman is responsible for receiving, attempting to resolve and investigating complaints related to Ontario's:

- **Public hospitals**
- **Long-term care homes and**
- **Home and Community Care Support Services**

If you were not satisfied with your care or a healthcare experience, you have the right to complain to Patient Ombudsman after you have attempted to resolve your complaint with the health organization in question.

1. Contact Information

First Name	Last Name	Preferred Name (Optional)	
Street Number	Street Name	Apt. or Suite #	
City		Province	Postal Code
Telephone		Email (Optional)	

Are you making this complaint on behalf of someone else?

☐ Yes ☐ No

If yes, please provide the following information about the patient, former patient or client. If no, skip to Section 2: Contact Preferences.

First Name	Last Name	Preferred Name (Optional)	
Street Number	Street Name	Apt. or Suite # (Optional)	
City		Province	Postal Code

Did the patient, former patient or client ask you to make this complaint?

☐ Yes ☐ No

Is that person deceased?

☐ Yes ☐ No

2. Contact Preferences

Please check preferred contact method.

☐ Telephone ☐ Regular Mail ☐ Email *

* Note: Patient Ombudsman cannot guarantee the privacy or security of information shared using email. By selecting this option, you confirm that you understand and accept the risks.

Please check preferred language.

☐ English ☐ French ☐ Other _____

Please identify any required accommodations.

☐ TTY device ☐ Interpreter ☐ Other _____

3. Health Organization Information

Organization Name			
Street Number	Street Name	Site or campus name (Optional)	
City		Province	Postal Code
Telephone		Email (Optional)	

Please check type of health organization.

☐ Public Hospital ☐ Long-term care Home ☐ Home & Community Care Support Services ☐ Other

Do you have contact details for the person at the health organization that dealt with your complaint?

☐ Yes ☐ No

If yes, please provide the following information about the person you had contact with at the organization.

First Name	Last Name	Position or Title and Department (Optional)
Telephone		Email (Optional)

Is there another health organization that you are concerned about?

☐ Yes ☐ No

If yes, please provide the name.
_____

4. Complaint Details

Please describe your complaint. Tell us what happened; who was involved; when and where it happened; when you became aware of the problem; the main issues with which you are concerned. Feel free to continue using additional pages.

What would you like to happen to resolve your complaint? For example, an apology, additional information, change to a policy, etc.

Did you attempt to resolve your complaint directly with the health organization?

☐ Yes ☐ No

If yes, please describe what resolution(s) the organization suggested.

Suggested Resolution

Did you complain to another organization or person?

☐ Yes ☐ No

If yes, please provide the name.
_____

5. Notice of Collection

Personal information on this form is collected by the Patient Ombudsman and staff of the Patient Ombudsman under the authority of s. 13.1, 13.2 and 13.3 of the *Excellent Care for All Act, 2010,* and of the *Freedom of Information and Protection of Privacy Act.* Information is used to contact you and to attempt to facilitate a resolution of a complaint to the Patient Ombudsman. Information could be used in an investigation by the Patient Ombudsman or staff of the Patient Ombudsman.

Questions about this collection should be directed to the Records Management & Privacy Specialist at 416.597.5377or 1-888-321- 0339.

If you are a caregiver or another person making a complaint on behalf of a patient, we need the consent of the patient or the patient's substitute decision-maker so that we can collect the patient's personal and personal health information in this form.

I assert that I have the consent of the patient or the patient's substitute decision-maker whose care or health care experience I have described in this form to disclose this information to the Patient Ombudsman and staff of the Patient Ombudsman.

Signature of Complainant	**Date Signed**

Once you have completed and signed this complaint form, please send it to our office using one of the methods below.

(a) Mail or courier to: Patient Ombudsman
Box 130, 77 Wellesley St. W.
Toronto, ON M7A 1N3

(b) FAX to: 416.597.5372

If you are having difficulties completing the form or have questions, you can contact us by telephone Monday to Friday from 9 a.m. to 4 p.m. We are here to help.

Toronto: 416.597.0339
Toll free: 1.888.321.0339
TTY: 416.597.5371