Upper Canada
Family Health Team

UCFHT Patient Concern Form
Patient Reporting

Date:

Person Registering the Concern:

First Name	Last Name
Address	
Daytime Phone Number + Area Code	
Evening Phone Number + Area Code	
Email Address	

Patient Information (if other than the person registering the concern)

First Name	Last Name
Address	
Daytime Phone Number + Area Code	
Evening Phone Number + Area Code	
Email Address	
Family Physician	

DETAILS OF THE CONCERN

Provide Details of your concern including the following as appropriate/applicable

Date of Incident:	Time of Incident:
Was this a CLINIC visit: O YES O NO	Was this a PROGRAM visit: O YES O NO
Name of the Healthcare team member(s) involved	
Doctor:	Nurse:
Receptionist:	Other:
Other:	Other:
What is your concern: (continued on reverse)	

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Describe any efforts you have made to resolve this matter:

Please describe the result or outcome that you seek:

Do you consider this matter urgent O YES O NO
If yes, please explain why:

Please forward the completed form to

Sherri Fournier-Hudson
Executive Director
Upper Canada Family Health Team
5 Home Street, Suite 4
Brockville, ON
K6V 0A5

EMAIL: info@ucfht.com
FAX: 613-423-3334

FOR OFFICE USE ONLY	
Concern received by	Date
Concern Investigated by	Date
Date response sent to client	Resolved O YES O NO