GLAZIER MEDICAL CENTRE

Patient Comment Form

Date:	
Your Contact Information	
Last Name:	First Name:
Address:	
Telephone (Day):	Telephone (evening):
Email:	
What is the best way to contact you? Telephone: ☐ Email : ☐ Mail: ☐	
Patient Information (if other than person filing complaint)	
Last Name:	First Name:
Address:	
Telephone (Day):	Telephone (evening):
Email:	

Please select the option that best describes the area for the feedback:

- ☐ Urgent Care
- ☐ Specialist
- ☐ Family Practice
- ☐ Travel Clinic
- ☐ Other
- ☐ Diagnostics – Holters
- ☐ Nursing
- ☐ Central Booking
- ☐ Switchboard

Details	
Date of Incident:	Time of Incident:
Location:	
Was this regarding an appointment? Yes ☐ No ☐	
Name(s) of Healthcare team member(s) involved: Physician:_____ Nurse:_____ Receptionist:_____ Other: _____	

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Patient Comment Form – Continued

What is your specific feedback?

Please describe any efforts you have made to resolve this matter:

Please describe the result or outcome that you seek:

FOR OFFICE USE ONLY	
Received by:	Date:
Investigated by:	Date:
Date Response Sent:	Resolved: Yes No

Print