Complaint Reporting Form

1. INSTRUCTIONS

1. **Complete this form with as much detail as possible.**
2. **Ensure all signatures are authorized and additional documentation is provided.**
3. **Mail/e-mail/fax the completed form to the College's Quality of Care department.**

Where appropriate, the Quality of Care (QoC) department reviews all information gathered regarding the complaint. The review may take several months, depending on the complexity of the complaint and the timeliness in which responses are received. Information may be requested from other individuals who have been identified to the QoC process. In some cases, an expert opinion may be sought.

When the QoC department completes its review, its opinion is conveyed, in writing, to the complainant (if authorised) and to the physician complained about. If there are concerns about the care provided by more than one physician, please complete a separate form for each physician complained about. If the complainant is dissatisfied with the findings, they are requested to write a letter indicating the areas of disagreement. The Senior Medical Advisor will review the letter of disagreement and may decide to revisit the matter through another process.

Before completing this form, please consider that the College is not able to:

- provide diagnoses or treatment recommendations or direct the specifics of patient care;
- direct or influence the payment of financial compensation to complainants;
- adjudicate complaints without offering the physician the opportunity to respond;
- assist with concerns or complaints about hospitals, or other health care providers such as nurses, pharmacists, dentists, optometrists, psychologists, chiropractors, naturopaths, or any other health professional that is not a registered physician or surgeon – these concerns should be directed to the appropriate organization or regulatory authority;
- initiate legal action against a physician;
- arrange referrals, consultations or tests.

Send completed form to:

Mail: Quality of Care
College of Physicians and Surgeons of Saskatchewan
101 - 2174 Airport Drive
Saskatoon, SK S7L 6M6

Fax: (306) 244-0090

E-mail: qualityofcare@cps.sk.ca
**please consider password protecting the document before sending to us through this method. and providing the password in a separate e-mail.*

For more information about the College's complaints process, please visit www.cps.sk.ca or call (306) 244-7355 or 1-800-667-1668 (toll-free in SK).

Thank you for taking the time to complete this form.

Checklist
Have you completed the following?

- ☐ Included full name(s) and address(es) of the physician(s) involved;
- ☐ described the complaint in as much detail as possible;
- ☐ enclosed copies of documents that may support this complaint;
- ☐ provided your name, telephone number and e-mail address where you can be reached during the day;
- ☐ signed and dated the *Authorisation for Release of Information* form;
- ☐ have the patient sign and date the authorisation of representation (if applicable);
- ☐ checked all pages of the complaint form to ensure all areas are complete and any additional sheets are attached.

(Office use only) OUR FILE:

2. AUTHORISATION FOR CONSENT AND RELEASE OF INFORMATION

Patient Consent

As the patient, I understand and that my signature to this release will allow the College of Physicians and Surgeons of Saskatchewan to:

1. Obtain any health record(s), including hospital records, physician office records, pharmaceutical prescription records and patient billing information, or other information relevant to the complaint.
2. Provide a copy of the letter of complaint and any pertinent information including medical records to the physician(s) named in the complaint.
3. Request, receive, photocopy and disseminate this information as necessary for the investigation of the complaint in accordance with the complaints process.

Patient First Name: _____ **Patient Last Name:** _____

How should we address you? ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mx. ☐ Dr. ☐ First Name ☐ Other _____

Patient date of birth: _____ **Patient health card #:** _____

_____ _____

Patient signature *Date signed*

3. AUTHORISATION FOR REPRESENTATION

Complete ONLY if you are NOT the patient or NOT the parent/legal guardian of a young child.

The patient may authorise the complainant (the person making the complaint) to receive information pertaining to the complaint. If so, the patient is required to complete the following:

I, _____, am aware of the complaint made to the College on my behalf, and authorise
Print Patient Name

_____ to receive medical information with respect to the review of this complaint.
Print Name of Person Filing the Complaint

4. IF THE PATIENT IS DECEASED

Privacy rights for deceased patients continue after death unless one of the exceptions stated in Section 27(4)(e) of The Health Information Protection Act (HIPA) applies:

(i) where the disclosure is being made to the personal representative of the subject individual for a purpose related to the administration of the subject individual's estate; or

(ii) where the information related to circumstances surrounding the death of the subject individual or services recently received by the subject individual, and the disclosure:
   a) is made to a member of the subject individual's immediate family or to anyone else with whom the subject individual had a closer personal relationship; and
   b) is made in accordance with established policies and procedures of the trustee, or where the trustee is a health professional, made in accordance with the ethical practices of that profession.

Person Filing Complaint Printed Name	*Person Filing Complaint Signature*	*Relationship to Patient*	*Date signed*

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A. PATIENT INFORMATION

First Name: _____ **Last Name:** _____

How should we address you? ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mx. ☐ Dr. ☐ First Name ☐ Other _____

Address: _____

City : _____ **Province:** _____ **Postal Code:** _____

Preferred phone #: _____ **Cell/Other:** _____ **E-mail:** _____

Date of birth: _____ (DD) - _____ (MMM) - _____ (YYYY) **Health card #:** _____

Preferred way of receiving communication? ☐ Mail ☐ *E-mail

**by providing your e-mail address you agree to receive correspondence from the College through this method. We will password protect any communication that includes personal health information, and we will send the password in a separate e-mail.*

_____ *Patient signature*

_____ *Date signed*

B. PERSON REGISTERING THE COMPLAINT

☐ I am the patient (*If the patient, do not complete section B – Skip to section C*)

☐ I am representing the patient for the purposes of this complaint and the patient has signed the authorisation for representation above.

☐ I am completing this complaint without authorisation from the patient.

First Name: _____ **Last Name:** _____

How should we address you? ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mx. ☐ Dr. ☐ First Name ☐ Other: _____

Address: _____

City : _____ **Province:** _____ : **Postal Code:** _____

Preferred phone #: _____ **Cell/Other:** _____ **E-mail:** _____

Preferred way of receiving communication? ☐ Mail ☐ *E-mail

**by providing your e-mail address you agree to receive correspondence from the College through this method. We will password protect any communication that includes personal health information, and we will send the password in a separate e-mail.*

_____ *Signature*

_____ *Date signed*

C. PHYSICIAN DETAILS

Identify the physician you are filing this complaint about. If known, provide the office address. If you are filing a complaint about more than one physician, you are required to complete a separate complaint reporting form for each physician.
A copy of this complaint will be sent to the physician you have identified.

Full of Name Physician: _____

Address : _____ **City:** _____ **Postal Code:** _____

Date(s) Attended : _____ _____ _____

Occurred at: ☐ **Office** ☐ **Hospital** ☐ **Other:** _____

Have you tried speaking with this physician about your concern? ☐ **Yes** ☐ **No**

D. OTHER DETAILS

Identify any other individual(s) who provided medical care or may have information relevant to your concerns (e.g. family physician, other physician or health care professionals).

Full Name: _____

Address : _____ **City:** _____ **Postal Code:** _____

Date(s) Attended : _____ _____ _____

Occurred at: ☐ **Office** ☐ **Hospital** ☐ **Other:** _____

Have you tried speaking with this individual about your concern? ☐ **Yes** ☐ **No**

E. DETAILS OF HOSPITAL/CARE FACILITY ATTENDED

Please provide the name(s) of the hospital(s) or care facility(ies) and dates you attended during this period.

Hospital/Care Facility 1 : _____ **City:** _____

Date(s) Attended : _____ _____ _____

Hospital/Care Facility 2 : _____ **City:** _____

Date(s) Attended : _____ _____ _____

F. EXPECTATIONS

What do you hope will happen as a result of this complaint process? ***The College has no legal authority to direct or influence the payment of financial compensation to the complainants.***

G. DETAILS OF YOUR COMPLAINT

Provide a clear description about the concerns you have about the physician. Include in your description what the physician did or failed hat led you to file this complaint. Please enclose copies of any documents you feel would be relevant to your case. ***A copy of this complaint will be sent to the physician you have identified.***

(Office use only) OUR FILE:

Attach additional pages if necessary.