Complaint Reporting Form

Instructions

1. Complete this form with as much detail as possible.
2. Ensure all signatures are authorized.
3. Ensure additional documentation is provided, where possible.
4. Mail the completed and signed form to the College's complaints department.

Where appropriate, the Complaints Resolution Advisory Committee reviews all information gathered in regard to 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 Complaints Committee. In some cases, an expert opinion may be sought.

When the Complaints Committee completes its review, its opinion is conveyed, in writing, to the complainant and to the physician(s) complained about. If the complainant is dissatisfied with the Committee's findings, he or she is requested to write a letter indicating the areas of disagreement. The Committee will revisit the matter.

Before you submit the 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(s) 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
- Contact the police on behalf of a complainant where illegal activities are suspected without the complainant's specific consent

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
- ○ Provide your name and telephone number where you can be reached during the day
- ○ Signed and dated the *Authorization for Release of Information* form
- ○ Signed and dated the patient consent (if applicable)
- ○ Checked all pages of the complaint form to ensure all areas are complete and any additional sheets

When you have completed this complaint form, please send it by:

Mail Complaints Department
College of Physicians and
Surgeons of Saskatchewan
101 - 2174 Airport Drive
Saskatoon, SK S7L 6M6

Fax (306) 244-0090

If you would like more information about the College's complaints process, please visit www.cps.sk.ca or phone (306) 244-7355 or 1-866-667-1668 (toll-free in SK).

Thank you for taking the time to complete this form.

A. Person Registering the Complaint

○ I am the patient and;

my date of birth is: _____ - _____ - _____ and my health card # is: _____ _____ _____
DD MM YYYY

○ I am representing the patient for purposes of this complaint.
My relationship to the patient is: _____
(example: parent, spouse, child, relative, lawyer, friend, physician, executor, Power of Attorney, etc)

Title (Mr. Ms. Miss): _____ First Name: _____ Last Name: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Phone: _____ Cell/Other: _____

B. Patient Information

If you are completing this form on the patient's behalf, please provide the following information about the patient:

Title (Mr. Ms. Miss): _____ First Name: _____ Last Name: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Phone: _____ Cell/Other: _____

Patient's information:
Date of Birth is: _____ - _____ - _____ Health card # is: _____ _____ _____
DD MM YYYY

When applicable: *As the patient, I consent to the College of Physicians and Surgeons of Saskatchewan disclosing information concerning my complaint, including personal identifiable information, such as diagnostic, treatment and patient care information to the person making the complaint on my behalf.*

_____ _____
Signature - Person Registering Complaint Date

_____ _____
Signature - Patient Date

C. Physician(s) Details

Identify the physician(s) you are filing this complaint about. If known, provide the office address. If you are filing a complaint about more than two physicians, please continue on a separate sheet. **A copy of this complaint will be sent to the physician(s) you have identified.**

Physician's Full Name: _____

Address: _____

City: _____ Postal Code: _____

Date(s) Attended: _____ _____ _____

Occurred At: ◯ Office ◯ Hospital ◯ Other: _____

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

Physician's Full Name: _____

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 professional. If there are more than two individuals, please continue on a separate sheet.

Physician's Full Name: _____

Address: _____

City: _____ Postal Code: _____

Date(s) Attended: _____ _____ _____

Occurred At: ◯ Office ◯ Hospital ◯ Other: _____

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

Physician's Full Name: _____

Address: _____

City: _____ Postal Code: _____

Date(s) Attended: _____ _____ _____

Occurred At: ◯ Office ◯ Hospital ◯ Other: _____

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

E. **Details of Your Complaint**

Provide a clear description about the concerns you have about the physician(s). Include in your description what the physician did or failed to do to cause you to complain. 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(s) you have identified.**

Attach additional pages if necessary.

F. **Summary of Questions:** list the questions you want the physician to answer. *Attach additional questions if necessary.*

1. _____

_____

2._____

_____

3._____

_____

4. _____

_____

5. _____

_____

G. **Expectations:** what you hope will happen as a result of this complaint process.
Please note: the College has no legal authority to direct or influence the payment of financial compensation to the complainants.

_____

_____

_____

_____

_____

_____

_____

_____

H. **Details of Hospital/Care Facility Attended**

Please provide the names of the hospital(s) or care facility(ies) and dates you attended during this period. If there are more than two, please continue on a separate sheet. **Please note: it may be necessary for the College to obtain hospital or facility records as part of its review of this complaint.**

Hospital/Care Facility: _____ City: _____

Date(s) Attended: _____ _____ _____

Hospital/Care Facility: _____ City: _____

Date(s) Attended: _____ _____ _____

Authorization for Consent and Release of Information

I, the undersigned, consent and authorize the release of information contained in **any health record(s), including hospital records, physician office records, pharmaceutical prescription records and patient billing information**, concerning the patient(s) to the College of Physicians and Surgeons of Saskatchewan. This will also provide consent for the College of Physicians and Surgeons of Saskatchewan to request, receive, photocopy and disseminate this information as necessary for the investigation of the above complaint in accordance with the complaints resolution process.

_____
Patient Full Name

Patient date of birth is: _____ - _____ - _____ Patient health card #: _____ _____ _____
DD MM YYYY

_____ _____
Signature - Patient Date signed

_____ _____
Signature – Person Registering the Complaint Date signed
(if you are not the patient)

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) (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.

A copy of the Certification of Appointment of Estate Trustee(s), Letter of Administration, or a copy of the document indicating you are entitle to receive personal health information of the deceased is required. You may only be entitled to a summary of the findings, excluding any of the subject individual's personal health information, if you do not have appropriate documentation.

_____ _____
Third Party/Legal Representative Printed Name Third Party/Legal Representative Signature

_____ _____
Date Signed Date Signed