Central Brampton
Family Health Team

Patient Feedback Form

Name:		Date:
Would you like someone to contact you about this issue?		Yes ____ No ____
Please describe the details of your concern, complaint and or compliment.		Phone number: ( ) -
Is this information about one person on our team?		Yes ____ No ___ If yes, who _____
In your opinion, due to your concern what might be a process that can improve your experience at Central Brampton FHT		
For Office Use Only	Received by (signature):	Date Received:
Report Given to : Executive Director _____	Date Received by ED:	Date of Patient Contact:
Summary of Communication with Patient *(to be completed by Executive Director)*		
Signature:	Outcome: Resolved _____	Further Action: _____