



HHHS Client Relations Feedback Form

Name: _____ | Mailing Address: _____
(client) Telephone #: _____

Date of Incident: _____ | Time of Incident: _____
Email: _____

Site: Haliburton Minden

Department:

Acute Care <input type="checkbox"/>	Highland Wood <input type="checkbox"/>	Supportive Housing <input type="checkbox"/>	Housekeeping <input type="checkbox"/>
Emergency <input type="checkbox"/>	Hyland Crest <input type="checkbox"/>	Health Information <input type="checkbox"/>	Laundry <input type="checkbox"/>
Radiology <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Business office <input type="checkbox"/>	Dietary <input type="checkbox"/>
Physiotherapy <input type="checkbox"/>	Diabetes Education <input type="checkbox"/>	Other _____ <input type="checkbox"/>	Maintenance <input type="checkbox"/>

SECTION 1

Issue: _____

Staff Response: _____

Date: _____ Signature: _____ Resolved Unresolved
(staff recording concern)

SECTION 2

MANAGEMENT USE ONLY

Date Received: _____

Action Taken: _____

Client Response: _____

Resolution: Resolved Unresolved

Additional Comments: _____

Signature: _____ Date of Resolution: _____

COPY 1 (WHITE) Quality/Risk Manager
COPY 2 (YELLOW) CEO
COPY 3 (PINK) Department copy