1000 – 1661 Portage Avenue
Winnipeg, MB R3J 3T7
Tel: (204) 774-4344
Toll Free (MB only) 1-877-774-4344
www.cpsm.mb.ca

COMPLAINT FORM

1. Patient Information:

Mx./Miss./Ms./Mrs./Mr./Dr. (Circle one)

Last Name _____

Given Name _____

Preferred Name _____

Preferred Pronouns _____

Birth Date _____

Manitoba Health No. _____

P.H.I.N. No. _____
(9-digit # on back of MHSC card)

Address _____

Town/City _____

Postal Code _____

Telephone (home) _____

Telephone (work) _____

Cell phone _____

Email: _____

2. If not the patient, information from the person making the complaint:*

Mx./Miss./Ms./Mrs./Mr./Dr. (circle one)

Last Name _____

Given Name _____

Preferred Name _____

Preferred Pronouns _____

Relationship to patient_____

Address _____

Town/City _____

Postal Code _____

Telephone (home)_____

Telephone (work) _____

Email: _____

*[Please note that only a legal representative of the patient or a deceased patient's estate (example: executor/executrix) may complain on a patient's behalf].

3. Provide the name of the physician complained about along with that physician's practice location. (If you are complaining about more than one physician, please submit a separate complaint form for each physician)

Physician (last name, first name or initials)	City/Town

4. Provide the name(s) of the hospital(s) attended either as an in-patient or for emergency/outpatient treatment relevant to the complaint, and the date(s) of those visit(s).

Name of Hospital	City/Town	Date(s)

5. Provide the name(s) of any other individual(s) who may have information pertaining to the complaint [e.g. family physician, other physician(s), or health care professional(s)].

Name	Location	Information

6. Provide a brief and clear description of the concern(s) you have about the physician named in the complaint.

If additional space is required, sign and number each page submitted.

7. In summary, please list in point form the questions/concerns you wish the physician to address.

If additional space is required, sign and number each page submitted.

8. What is your expectation from the review of this complaint? Please note that CPSM cannot award financial compensation, refer patients to physicians or arrange medical treatment/diagnostic tests.

_____ _____

Signature of person making complaint Date

_____

Print Name