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Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

Office of
Patient Relations
Here for you

COMPLAINT FORM

The Office of Patient Relations, Department of Health, Government of Nunavut is responsible for investigating and resolving conflicts between patients and healthcare providers. The investigation process may include disclosure of personal identifiable information related to your health records. The process time can very depending on the severity of the issue.

THE PROCESS
To begin an inquiry into your complaint, please complete this form and attach any additional information or descriptions you want included that are related to your case.

Please email or mail back this form to the Office of Patient Relations. To ensure confidentiality, no faxes are accepted.

Once the document is received – the Office of Patient Relations will then:

1) Acknowledge receipt, and send a copy of your completed form to the appropriate Executive Director and regional point person closest to the healthcare provider in question to obtain a response.
2) Contact other individuals and/or institutions named in your completed form that may have information relevant to your issue.
3) Review all information received.
4) Provide you with either a written or verbal response to the review depending on complexity.

If you have any questions or need help completing this form, please contact the Territorial Manager Patient Relations at 1-855-438-3003.

For more information: www.patientrelations.gov.nu.ca

1 Information from the person making the complaint:

(Ms/Mrs/Mr/Dr) ______________________________
(first name) (last name)

Address ______________________________

City ____________ Postal Code ____________ Email ____________

Telephone number with area code where we can contact you during the day (8:30 a.m. - 4:00 p.m.)

Home ( ) ____________ Work ( ) ____________ Mobile ( ) ____________

(If you are filing this complaint on behalf of the patient, please provide a copy of the documentation authorizing your permission. Examples include - executor of an estate, legal guardian, or patient's written consent)

2 Patient information

Birth Date (dd/mmm/yyyy) ____________ Nunavut Health Care # ____________

☐ Address information same as above

(Ms/Mrs/Mr/Dr) ______________________________
(first name) (last name)

Address ______________________________

City ____________ Postal Code ____________ Email ____________

Telephone number with area code where we can contact the patient during the day (8:30 a.m. - 4:00 p.m.)

Home ( ) ____________ Work ( ) ____________ Mobile ( ) ____________

3 **Provide a clear description of the complaint(s) you have about the health service or provider(s). Please include in your description what the healthcare provider did or failed to do to cause your concern, including**

1. What happened?
2. Where it happened?
3. When it happened?
4. What do you hope will happen as a result of your concern?

Please attach any relevant information that will assist in this inquiry.

Signature of person making complaint

Date signed (dd/mmm/yyyy)

I understand my signature on this release allows the Department of Health, Government of Nunavut where applicable to

1. Obtain medical records or other information relevant to my issue(s)
2. Provide a copy of my formal complaint to the healthcare provider named in order to obtain a response
3. Disclose, where applicable, information concerning my complaint including person identifiable information, diagnostic, treatment and care information to the person making the complaint on my behalf.

Completion of this form remains confidential, as otherwise indicated above.

Signature of Patient

Date signed (dd/mmm/yyyy)

If the patient is deceased, please provide the date of death

Date of death (dd/mmm/yyyy)

Our Address:
Office of Patient Relations
Department of Health
P.O. Box 1000, Station 1000
Iqaluit, Nunavut X0A 0H0
1-855-438-3003 patientrelations@gov.nu.ca